

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The State of South Dakota requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

CHOICES

C. Waiver Number:SD.0044

Original Base Waiver Number: SD.0044..90.R4

D. Amendment Number:SD.0044.R08.05

E. Proposed Effective Date: (mm/dd/yy)

10/01/21

Approved Effective Date of Waiver being Amended: 06/01/18

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The South Dakota Dept. of Human Services/Division of Developmental Disabilities (DHS/DDD) is requesting a change to make supplemental payments to Community Support Providers that have a signed care coordination agreement with Indian Health Services to ensure access and proper coordination of care of health services.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration	

Component of the Approved Waiver	Subsection(s)
and Operation	
Appendix B Participant Access and Eligibility	
Appendix C Participant Services	
Appendix D Participant Centered Service Planning and Delivery	
Appendix E Participant Direction of Services	
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

Modify target group(s)

Modify Medicaid eligibility

Add/delete services

Revise service specifications

Revise provider qualifications

Increase/decrease number of participants

Revise cost neutrality demonstration

Add participant-direction of services

Other

Specify:

Add supplemental payment

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The State of South Dakota requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (optional - this title will be used to locate this waiver in the finder):

CHOICES

C. Type of Request: amendment

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

3 years 5 years

Original Base Waiver Number: SD.0044

Waiver Number: SD.0044.R08.05

Draft ID: SD.005.08.05

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 06/01/18

Approved Effective Date of Waiver being Amended: 06/01/18

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

not applicable

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**2. Brief Waiver Description****Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The CHOICES (Community, Hope, Opportunity, Independence, Careers, Empowerment, Success) waiver program is a 1915(c) waiver designed to provide community-based services and supports to South Dakotans with intellectual/developmental disabilities who would otherwise require institutional level of care. The goal of the CHOICES waiver is to assist individuals in leading healthy, independent and productive lives to the fullest extent possible; promote the full exercise of their rights as citizens of the state of South Dakota; and promote the integrity of their families.

The objectives of CHOICES are to:

- Deliver services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of safeguards;
- Offer an alternative to institutionalization through the provision of an array of services and supports that promote community inclusion and individuality by enhancing and not replacing existing natural supports;
- Encourage individuals and their families to exercise their rights and share responsibility for the provision of their services and supports; and
- Offer a platform for a person-centered system based on the needs and preferences of the individual.

The Department of Human Services, Division of Developmental Disabilities (DHS/DDD), through a Memorandum of Understanding with the Single State Medicaid Agency (SSMA), operates CHOICES. The SSMA in South Dakota is the Department of Social Services, Division of Medical Services. CHOICES provides services and payment for those services that are not offered under the State Medicaid Plan. CHOICES services are offered statewide. Case management is provided by qualified Medicaid providers that do not provide direct supports to the same individual. The individual's Case Manager assures that the individual's needs are assessed and identified for each service.

3. Components of the Waiver Request**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

Limited Implementation of Participant-Direction. A waiver of statewide is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state. *Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:

Public notice and comment period of the CHOICES waiver amendment occurred between June 8, 2020 and July 8, 2020. Public notice was posted in a 24 hour accessible location within the local DHS/DDD office in Pierre, SD. A hard copy of the proposed changes to the CHOICES waiver was also made available. Public notice and proposed changes to the CHOICES waiver were posted to the DHS/DDD website for public access and public notice of the amendment was posted to the South Dakota Legislative Research Council's website (<http://legis.sd.gov/>) during the 30 day comment period.

There are nine Tribal Nations in South Dakota. The Governor of South Dakota created a Tribal Relations Department within State Government. The Secretary of Tribal Relations is a registered member of a Tribal Nation. T The Chairperson/President of each Tribal Nation were e-mailed a notice of intent to amend the CHOICES waiver, and notice of the public input on June 8, 2020 via the Medicaid Tribal Consultation list.

The South Dakota Medicaid Advisory Committee meets twice annually. Members of that group are encouraged to provide comments during the public comment period for all State Plan and Waiver Renewals/Amendments. The CHOICES waiver administrator presented the waiver amendment to the Medicaid Advisory Committee via email.

There were no comments or questions presented during the public comment period.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Hynes

First Name:

Samantha

Title:

Policy/Strategy Manager

Agency:

Department of Social Services, Division of Medical Services

Address:

700 Governors Drive

Address 2:

City:

Pierre

State:

South Dakota

Zip:

Phone:**Ext:** **TTY****Fax:****E-mail:**

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:**First Name:****Title:****Agency:****Address:****Address 2:****City:****State:****Zip:****Phone:****Ext:** **TTY****Fax:****E-mail:**

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

10/18/2021

State Medicaid Director or Designee

Submission Date:

Oct 18, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

Hynes

First Name:

Samantha

Title:

Policy Strategy Manager

Agency:

South Dakota Department of Social Services

Address:

700 Governors Drive

Address 2:

City:

Pierre

State:

South Dakota

Zip:

57501

Phone:

(605) 773-3495

Ext:

TTY

Fax:

(605) 773-5246

E-mail:

Attachments

samantha.hynes@state.sd.us

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

Replacing an approved waiver with this waiver.

Combining waivers.

Splitting one waiver into two waivers.

Eliminating a service.

Adding or decreasing an individual cost limit pertaining to eligibility.

Adding or decreasing limits to a service or a set of services, as specified in Appendix C.

Reducing the unduplicated count of participants (Factor C).

Adding new, or decreasing, a limitation on the number of participants served at any point in time.

Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

The Department of Human Services/Division of Developmental Disabilities (DHS/DDD) will update the service title of Prevocational Services with Career Exploration and will implement a time limit. Within one year of June 1, 2020, the participant receiving Career Exploration and their team will meet to determine if Career Exploration continues to be the best service option for the participant. The time required to successfully end Career Exploration and transition the participant into competitive employment and/or integrated community activities will also be discussed at that time. The time required will be reviewed and authorized by the DHS/DDD. This process will be monitored via internal tracking systems within the DHS/DDD to ensure all CHOICES participants do not exceed a maximum of 24 months of Career Exploration supports unless prior authorization from the DDD is granted after receiving additional documentation from the participant's case manager stating necessary steps/changes in supports and approaches to help the participant reach their desired employment outcome. Each participant's time limit will begin on June 1, 2021.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

Department of Human Services, Division of Developmental Disabilities (DHS/DDD)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DHS/DDD operates the CHOICES Waiver and the Department of Social Services (DSS), Single State Medicaid Agency, is responsible for the oversight of the waiver. DSS and DHS have a MOU, signed by the Cabinet Secretary of each Department, defining the responsibilities of each.

DSS, to exercise administrative authority and supervision of the waiver, responsibilities are:

- To pay DHS Medicaid claims through the DSS Medicaid Management Information System;
- To approve the Home and Community-Based Services (HCBS) Waiver programs operated by DHS and submit approved waiver requests to the federal government;
- To coordinate quarterly Internal Waiver Review Committee (IWRC) meetings;
- To monitor DHS operation of HCBS Waiver programs through review of annual performance measures report submitted to DSS;
- To review changes proposed by DHS in DSS Medicaid regulations; to make recommendations to DHS regarding compliance with federal statutes, rules, and regulations; and to submit changes in Medicaid rules and regulations proposed by DHS in accordance with South Dakota's Administrative Procedures Act;
- To review and approve Medicaid State Plan amendments proposed by DHS and to forward approved amendments to the federal government;
- To furnish DHS on a timely and regular basis with such reports and information as may be required to ensure that DHS can satisfy state and federal responsibility requirements;
- To seek review and comment from DHS prior to the promulgation of any rules, regulations, or standards that may affect the services, programs, or providers of services for eligible individuals served by Medicaid funded DHS programs;
- To assist DHS as requested in maintaining the rate-setting and financial accountability standards required by CMS. DSS serving as the SSMA has provided through approved rate setting and financial accountability assurances to the federal government that Title XIX funds are used for the sole purpose of providing Title XIX services;
- To provide assurance to the federal government by completing random reviews of the reported Title XIX expenditures;
- To maintain the State's Title XIX Medicaid Administrative Rules chapter and to have primary responsibility for the State's Title XIX State Plan;
- To work cooperatively with DHS to prioritize information technology projects for programs managed by DHS relating to the DSS Medicaid Management Information System;
- To maintain primary responsibility for the Title XIX eligibility determination process;
- To perform the administrative hearings process for DHS when the issue arises from administrative rules found in ARSD Title 67;
- To immediately notify the applicable DHS Division Director of requests for a hearing regarding eligibility issues for the Title XIX Medicaid programs administered by DHS;
- To immediately forward all pending hearing decisions regarding eligibility issues for the Medicaid funded DHS programs to DHS; and
- To make disability determinations through the DSS Disability Incapacity Consultation Teams.

DHS, delegated as the operational authority of the waiver, responsibilities are:

- To develop regulations for new or revised DHS program objectives; to present and defend Medicaid regulations proposed by DHS to the Legislative Research Council and the Interim Rules Review Committee;
- To participate in quarterly IWRC meetings;
- To notify the State Medicaid Director (SMD) or designee of new or proposed changes to Title XIX Medicaid programs including significant changes to regulations or standards of existing programs so DSS may review the proposed changes and provide comments;
- To develop proposed Medicaid State Plan and Waiver amendments as required for DHS Title XIX programs and services and to submit such proposals, along with summary information on proposed changes, to DSS for review, approval and submission to CMS;
- To provide documentation and assurances to DSS as requested supporting appropriate expenditures and related nonfederal match (including that provided by local school districts) of Title XIX funds as a provision of accepting those funds ;
- To meet sub-recipient audit requirements of the Single Audit Act and associated Uniform Grant Guidance;
- To maintain program standards and to monitor the provision of services for people served by DHS Medicaid programs;

- To report suspected fraudulent practices by DHS providers to DSS's Surveillance and Utilization Review (SURS) unit;
- To facilitate financial recoveries necessitated by erroneous, fraudulent or abusive practices by DHS providers and to work with DSS on proper handling of these recoveries;
- To accept total responsibility for the portion of the state's federally-established quality control error rate resulting from DHS errors, including any financial penalties and development of appropriate corrective action;
- To accept responsibility should there be federal audit exceptions related to DHS's involvement with Title XIX Medicaid funding;
- To assist in the resolution of pended and denied claims;
- To assist in training and communication with providers serving DHS Medicaid programs regarding policy or billing changes;
- To work cooperatively with DSS and the SMD in the administration of the Medicaid Program;
- To comply with all rules and regulations governing the Medicaid Program;
- To provide information necessary for DSS to function effectively as the SSMA;
- To operate all approved DHS Medicaid funded programs in compliance with all federal and state statutes, rules, and regulations, and provide reports detailing program implementation, participants served, and other performance measures specified by DSS;
- To work cooperatively with DSS as the administrative authority when implementing HCBS waiver changes, amendments and renewals initiated by DHS as the operating agency;
- To identify business requirements for information technology projects relating to the DSS Medicaid Management Information System for programs managed by DHS;
- To work cooperatively with DSS to prioritize information technology projects for programs managed by DHS relating to the DSS Medicaid Management Information System;
- To participate in the administrative hearings process when the issue arises from that part of ARSD Title 67 addressing DHS administered programs funded by Title XIX; and
- To review all pending hearing decisions regarding eligibility issues for the Title XIX Medicaid Waiver Programs administered by DHS and file any written objection to the pending decision within ten days of notice of the pending decision. The Cabinet Secretary of DHS shall retain authority to accept, reject, or modify the final decision.

As the SSMA, DSS will continue its role with regard to federal reporting and cost allocation matters involving Title XIX. DSS fiscal staff will continue to be responsible for the following financial activities:

- Preparation and submission of quarterly projections of Title XIX expenditures for future quarters to the federal government;
- Preparation and submission of federally mandated reports of actual Title XIX expenditures to the federal government;
- Explanation of variances between projected and actual Title XIX expenditures to the federal government;
- Drawdown of all Federal Title XIX cash for the state;
- Review of cost allocation plans involving Title XIX funding prior to submission to the federal government; and
- Review of responses to federal reviews and audits involving Title XIX prior to submission to the federal government.

Through participation on the Internal Waiver Review Committee (IWRC), as described in Appendix H of this application, the DHS/DDD will collect and aggregate CHOICES waiver data to be submitted to DSS for review. The waiver data submitted to DSS includes number of waiver participants, number of new applicants and approved levels of care, number and resolutions of critical incidents reported, number and resolution of participant complaints, number and resolution of any fair hearings, and a comprehensive report of each waiver assurance and respective CMS approved performance measures containing total compliance reviews completed for each measure, the total elements not applicable, the total elements compliant/noncompliant and the total percent of elements compliant/noncompliant. This report also includes internal tracking of DHS performance in conducting operational functions (i.e. DHS/DDD staff quality assurance reviews conducted by DHS/DDD management staff). Other key items and waiver data concerning relevant matters will be discussed and/or submitted upon the request of DSS.

DSS will perform monitoring and oversight of delegated operational responsibilities of DHS. All initial and annual level of care determinations are referred by DHS/DDD to a DSS benefits specialist for review and

approval/denial. A DSS-EA-266 Notice, including right to appeal, is sent to each participant by DSS as described further in Appendix F.

DHS performs prior authorization of waiver services. DSS provides oversight of this function through edit controls on the MMIS.

DHS calculates waiver payment amounts and/or rates in preparation for waiver application/renewal and submission of the 372 report to CMS. This information is then sent to DSS for review and approval/denial.

During the period prior to waiver application/renewal, DSS and DHS collaborate on completing each of the appendices of the new waiver template. DHS is responsible for drafting and forwarding each appendix to DSS for review and approval/denial.

DSS and DHS have a strong cooperative relationship in the operation of the CHOICES waiver. Clear and strong lines of communication between the two department's management staff, fiscal staff and cabinet secretaries are well established. Both departments work together to ensure that the waiver is operated in accordance with Medicaid rules. In all oversight activities, DHS collaborates with DSS to review and analyze findings, develop strategies for improvement, and make timely changes to the program, as indicated. If DSS identifies any issues that are inconsistent with Medicaid requirements at any time, DSS ensures that DHS corrects the problem.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the

responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		

Function	Medicaid Agency	Other State Operating Agency
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of a statistically valid sample of participant records reviewed by the operating agency as required by the SSMA. Numerator: Total number of a statistically valid sample of participant records reviewed by the operating agency. Denominator: Total number of participant records that require review according to the sample.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of operating agency and SSMA agreed upon reports that were submitted timely by the operating agency. Numerator: The number of agreed upon reports submitted timely to the SSMA. Denominator: The total number of agreed upon reports.

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of provider plan of enhancements implemented timely upon the discovery of systemic deficiencies. Numerator: Total number of provider plan of enhancements implemented timely. Denominator: Total number of provider plan of enhancements as required by SSMA.

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and	Other

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

The number and percent of new providers enrolled by the operating agency according to SSMA requirements. Numerator: The total number of new providers enrolled according to SSMA requirements. Denominator: The total number of new providers enrolled.

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/> Upon enrollment of a new provider.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

The number and percent of provider rates established by the operating agency that are approved by the SSMA prior to implementation. Numerator: The number of provider rates approved by the SSMA prior to implementation. Denominator: The total number of rates implemented.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

The number and percent of a statistically valid sample of provider claims reviewed by the operating agency as required by the SSMA. Numerator: Total number of a statistically valid sample of provider claims reviewed by operating agency. Denominator: Total number of provider claims that require review.

Data Source (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95%</div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of waiver participants that are maintained within approved waiver limits by operating agency. Numerator: The total number of waiver participants. Denominator: The approved number of unduplicated waiver participants.

Data Source (Select one):**Operating agency performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check</i>	Frequency of data collection/generation (<i>check</i>	Sampling Approach (<i>check each that applies</i>):
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<i>each that applies):</i>	<i>each that applies):</i>	
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

The number and percent of provider certifications renewed by the operating agency as required by the SSMA. Numerator: Total number of existing providers that received a two-year certification renewal by the operating agency. Denominator: Total number of existing providers that require certification renewal.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of waiver expenditures that are maintained within approved waiver limits by operating agency. Numerator: The total waiver expenditures.

Denominator: The total waiver expenditures approved in the waiver.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

Other Specify: 	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system to compile and calculate Administrative Authority performance measures for the CHOICES waiver. SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD review of compliance with SSMA oversight of the performance of waiver functions including participant enrollments, level of care evaluations, provider compliance reviews, provider Plan of Enhancements, and provider certification requirements. SMART aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvement. SMART affords the SSMA to review remediation and improvement efforts. It is also available to the SSMA as a tool to generate reports on any area of performance for each of the waiver assurances for a specified time period.

In 2017 the DDD re-defined the role of key positions within the division to further enhance existing quality assurance processes. The DDD created the Office of Waiver Management (OWM) and a Quality Assurance Manager position. The OWM consists of a Waiver Administrator and two Qualified Intellectual Disability Professionals (QIDP). The OWM will provide oversight for all participant levels of care, waiver amendments, renewals, and other waiver related functions as needed. The Quality Assurance Manager will work within the SMART system, the Critical Incident Report system, and other existing quality assurance systems to analyze data, identify trends, and generate reports to assist DHS/DDD Program Specialists in identifying opportunities for technical assistance to their assigned providers.

The SMART system enables the DHS/DDD to query Administrative Authority performance data to monitor for systemic trends in compliance with SSMA procedures. The Quality Assurance Manager is responsible for completing the aggregation and analysis of this information on a continuous basis. The results of the data analysis are discussed with the SSMA minimally on a quarterly basis during Internal Waiver Review Committee meetings. Additionally, the SSMA can review data within the SMART system at any time since the SSMA is equipped with direct access to the system.

The Office of Waiver Management is responsible to conduct a quality assurance oversight review of all participant enrollments and level of care evaluations completed by DHS/DDD Program Specialists to assure procedures required by the SSMA are followed. If the Waiver Administrator identifies a systemic issue within participant enrollments or level of care evaluations this information is shared with DHS/DDD management to be corrected as a performance issue. The Office of Waiver Management is also responsible to assure that a statistically valid sample of participant plans and provider claims are reviewed and reported to the SSMA. The DHS/DDD oversees each provider for compliance with a systemic Plan of Enhancement and assures provider certification according to SSMA procedures. DHS/DDD oversight of SSMA procedures and associated performance results are accessible to the SSMA for analysis and feedback.

The DHS/DDD monitors and manages waiver enrollment and expenditures against approved limits. Each quarter the DHS/DDD reports the results to the SSMA.

All provider rates are established by the operating agency and submitted to the SSMA for billing authorization.

b. Methods for Remediation/Fixing Individual Problems

- i.** Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Individual problems are discovered through a series of quality assurance reviews and the utilization of the SMART system. Each identified error in Administrative Authority performance is corrected at the individual level through a remediation process and the data monitored for systemic issues. At the time the data is shared with the SSMA the errors and/or systemic issues have been addressed. The DHS/DDD is able to provide the SSMA remediation activities completed and necessary systemic adjustments made, for example memos issued to providers or technical assistance provided to a specific provider. If the Quality Assurance Manager finds that data indicates systemic issues the Quality Assurance Manager will notify the Waiver Administrator and the Waiver Administrator will determine necessary revisions to internal processes. Process changes will be approved by the SSMA and DDD management prior to implementation. The SSMA provides additional direction as necessary to ensure compliance with the written waiver. Results of Administrative Authority performance are available for review by the SSMA at any time. Results are also provided to core stakeholders via the DDD Advisory Group.

The Office of Waiver Management will conduct a quality assurance oversight review of all participant enrollments and LOC evaluations completed by DHS/DDD staff to assure procedures required by the SSMA are followed. This includes the review of the necessity of specific waiver services before they are authorized, as described in Appendix B. If an error is discovered during the review (e.g. the ICAP is scored incorrectly, the diagnosis within the psychological was misinterpreted, or the applicant is eligible but was determined ineligible by the Qualified Intellectual Disability Professional or qualified DHS/DDD staff), the DHS/DDD Program Specialist will have ten days to fix the problem. Once the problem is corrected and confirmed by the Office of Waiver Management, the SSMA is able to review the corrected problem and provide feedback.

As part of SSMA procedures, the DHS/DDD is required to conduct a statistically valid sample of participant records and report the progress made toward completion of the sample size to the SSMA. The Office of Waiver Management is responsible for determination of the sample size of participant record reviews each waiver year. This is accomplished by utilizing historic review data and applying a 95% confidence level and 5% confidence interval. The sample size is divided by 12 to determine the number of reviews that must be completed each month. Quarterly, the Office of Waiver Management reviews the total number of participant records sampled to ensure the total number of required reviews will be achieved. If the Office of Waiver Management determines the necessary number of records will not be achieved the total number of files reviewed in the subsequent months is increased. This will ensure the identified sample size of participant record reviews is achieved.

The DHS Management Analyst will conduct a proportionate random sample of provider claims as required by the SSMA. This is accomplished by utilizing historic review data and applying a 95% confidence level and 5% confidence interval. The sample size is divided proportionately based on the population size of the qualified provider. Each qualified provider will receive a claims audit biennially, coinciding with the second year of the qualified provider's certification. Quarterly, the Office of Waiver Management reviews the total number of provider claims reviewed to ensure the total number of required reviews will be achieved. If the total number of claim reviews are not on pace to be achieved, the Office of Waiver Management shall meet with the DHS Office of Budget and Finance to determine an appropriate timeline and schedule to meet the sample size required by the SSMA. The SSMA is provided with progress made towards the sample size quarterly.

The DHS/DDD will conduct biennial certification reviews for each provider to assure compliance with Administrative Rules of South Dakota, the Medicaid provider agreement, the agreement with the DHS/DDD and accreditation requirements. Subsequent to the all remediation of problems discovered, any follow-up actions by the qualified provider as a result of the discovery of problems, and a DHS/DDD approved Plan of Enhancement, the total number of providers that received certification renewal as well as those providers that do not meet certification renewal requirements will be reported to the SSMA.

The DHS/DDD financial manager monitors the DHS/DDD management of waiver enrollment and waiver expenditures and meets with DHS/DDD Director, DHS Budget and Finance management, and the Waiver Administrator monthly to assure appropriate levels are maintained. The results are submitted to the SSMA quarterly. If waiver enrollment/expenditure amounts reach concerning levels, the DHS/DDD will meet with the SSMA to determine appropriate action.

The Quality Assurance Manager is responsible to ensure all agreed upon reports are submitted to the SSMA in a timely manner. If it is discovered this step in the process is missed the agreed upon report will be immediately provided to SSMA for review and approval. Adjustments to any agreed upon report is made as directed by the

SSMA and the new report will be provided to appropriate stakeholders as necessary.

The SSMA is highly involved in the process of new provider enrollment and provider rate methodology. Issues are identified during the process itself and remediated at that time.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> Internal Waiver Review Committee Core Stakeholder Group </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age					
				Maximum Age Limit			No Maximum Age Limit		
Aged or Disabled, or Both - General									
		Aged							

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age			
				Maximum Age Limit		No Maximum Age Limit	
		Disabled (Physical)					
		Disabled (Other)					
Aged or Disabled, or Both - Specific Recognized Subgroups							
		Brain Injury					
		HIV/AIDS					
		Medically Fragile					
		Technology Dependent					
Intellectual Disability or Developmental Disability, or Both							
		Autism					
		Developmental Disability		0			
		Intellectual Disability		0			
Mental Illness							
		Mental Illness					
		Serious Emotional Disturbance					

b. Additional Criteria. The state further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state.

Complete Items B-2-b and B-2-c.

The limit specified by the state is *(select one)*

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2709
Year 2	2726
Year 3	2743
Year 4	

Waiver Year	Unduplicated Number of Participants
	2760
Year 5	2777

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

- e. Allocation of Waiver Capacity.**

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

If a waiting list develops, DHS/DDD will assign a level of priority for entrants to the waiver. The first level is "priority status" which is defined as individuals who are at significant risk of institutionalization. All other individuals are placed in the second level, which is "applicant status." Significant risk means:

Individuals at imminent risk of being homeless or institutionalized;
Individuals who are homeless or institutionalized;
Individuals currently residing in an abusive, neglectful, exploitive or life-threatening situation; and
Individuals whose health, welfare or safety is in jeopardy.

Individuals in "priority status" will be placed at the top of the waiting list and receive services on a first come first serve basis. An individual who is at risk of abuse, neglect, or exploitation will be prioritized on the priority level list. A referral will be made to the Department of Human Services, Division of Long-Term Services and Supports as the State's Disability Protection Agency and other programs will be explored. Individuals in "applicant status" will receive services on a first come first serve basis but after those in priority status.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a (*select one*):

§1634 State

SSI Criteria State

209(b) State

2. Miller Trust State.

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients**Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121****Optional state supplement recipients****Optional categorically needy aged and/or disabled individuals who have income at:***Select one:***100% of the Federal poverty level (FPL)****% of FPL, which is lower than 100% of FPL.**Specify percentage: **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)****Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)****Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)****Medically needy in 209(b) States (42 CFR §435.330)****Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)****Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)***Specify:*

Special home and community-based waiver group under 42 CFR §435.217 *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.***Select one and complete Appendix B-5.***All individuals in the special home and community-based waiver group under 42 CFR §435.217****Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217***Check each that applies:***A special income level equal to:***Select one:***300% of the SSI Federal Benefit Rate (FBR)****A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the state elects to (*select one*):

Use spousal post-eligibility rules under §1924 of the Act.

(Complete Item B-5-b (SSI State) and Item B-5-d)

Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.

(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (select one):

The following standard included under the state plan

Select one:

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

(select one):

300% of the SSI Federal Benefit Rate (FBR)

A percentage of the FBR, which is less than 300%

Specify the percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

The following formula is used to determine the needs allowance:

Specify:

The SSI Federal Benefit Rate. If working, an additional amount of monthly wages to bring the maintenance needs allowance to a maximum of 300% of the SSI federal benefit rate.

Other

Specify:

ii. Allowance for the spouse only (select one):

Not Applicable

The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

The amount is determined using the following formula:

Specify:

Other

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state establishes the following reasonable limits

Specify:

Only those necessary medical or remedial care services prescribed by a physician that are not covered by Medicaid or any third party and incurred during a period which is no more than three months prior to the month of current application will be allowed as an income deduction.

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (3 of 7)**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (4 of 7)**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

SSI standard

Optional state supplement standard

Medically needy income standard

The special income level for institutionalized persons

A percentage of the Federal poverty level

Specify percentage:

The following dollar amount:

Specify dollar amount:

If this amount changes, this item will be revised

The following formula is used to determine the needs allowance:

Specify formula:

Other

Specify:

The SSI Federal Benefit Rate. If working, an additional amount of monthly wages to bring the maintenance needs allowance to a maximum of 300% of the SSI federal benefit rate.

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

Allowance is the same

Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

- Health insurance premiums, deductibles and co-insurance charges
- Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

The state does not establish reasonable limits.

The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g.,

quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By a government agency under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial level of care evaluation is conducted by the DHS/DDD Qualified Intellectual Disability Professional (QIDP) within the Office of Waiver Management as specified in 42 CFR 483.430 (a) or a qualified DHS/DDD staff. The QIDP has at least one year experience working directly with people with an intellectual disability or other developmental disabilities and holds at least a bachelor's degree in a professional category or is a registered nurse. A qualified DHS/DDD staff has five years equivalent training and work experience AND knowledge of the public service system for ID/DD in South Dakota.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The criteria for entrance into an ICF-ID/DD are as follows:

1. The individual must be developmentally disabled as defined in ARSD 67:54:03:03 (criteria for determining developmental disability); and
2. The QIDP or qualified DHS/DDD staff must determine that the individual is in need of ICF-ID/DD services pursuant to ARSD 67:54:03:04 (determination of need for ICF-ID/DD services).

The Level of Care criteria used to evaluate whether an individual needs CHOICES waiver services are:

1. ICAP (Inventory for Client and Agency Planning) eligibility with a minimum of 3 functional limitations;
2. Psychological examination to determine intellectual or developmental disability;
3. HCBS Waiver Rights Form (DHS-DD-717) to inform the applicant that services are available from the Home and Community Based Services Waiver. This form also assures each applicant is provided with a list of HCBS providers, informed of the appeal process for denial of services if the applicant is determined not eligible, and provided with contact information to request a fair hearing; and
4. A provisional plan of care that designates the specific waiver services that the participant will receive.

The Level of Care criteria used to reevaluate whether an individual has a continued need for CHOICES waiver services is ICAP eligibility with a minimum of 3 functional limitations.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The process used for evaluating/reevaluating the level of care for waiver participants is as follows:

Initial Evaluation:

The individual's selected case manager gathers all forms and information listed below and submits to DHS/DDD for initial evaluation. These forms are:

1. ICAP eligibility with a minimum of 3 functional limitations;
2. Psychological examination to determine developmental disability or intellectual disability; and
3. HCBS Waiver Rights Form (DHS-DD-717) to inform the applicant that services are available from the Home and Community Based Services Waiver. This form also assures each applicant is provided with a list of HCBS providers, informed of the appeal process for denial of services if the applicant is determined not eligible, and provided with contact information to request a fair hearing; and
4. A provisional plan of care that designates the specific waiver services that the participant will receive.

The Office of Waiver Management QIDP or qualified DHS/DDD staff determines initial level of care eligibility. The QIDP or qualified DHS/DDD staff then completes the DHS-DD-730 form (recommending to the SSMA the effective date of initial level of care eligibility). This form is sent to the individual's chosen providers and SSMA.

Re-evaluation:

Re-evaluation is performed annually. From the Level of Care criteria described above, the state uses a completed ICAP that results in a minimum of three functional limitations assessed by a QIDP or qualified DHS/DDD staff to reevaluate whether an individual has a continued need for CHOICES waiver services.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

DHS/DDD completes reevaluations of participant level of care annually based on each participant's current ICAP. Each participant must have at least three functional limitations as identified through the ICAP assessment to remain eligible for CHOICES waiver services.

The ICAP assessment is required to be updated as a participant's needs change. The ICAP assessment is also required to be updated and submitted to the DHS/DDD no later than every three years on January 15. ICAP is a core component for rate setting and budget projections. If information is not received in the required timeframe, the provider is contacted and has 3 business days to submit the required information. If the information is not submitted within 3 business days, the provider risks losing HCBS payments for services rendered to the participant for whom the required information is not furnished. At least annually the DHS/DDD will conduct reevaluations to assure continued HCBS level of care eligibility.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The participant's case manager maintains these records. A copy is retained at the DHS/DDD office.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

- a. **Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participants who had a level of care completed prior to the initiation of services. Numerator: The number of participants with a level of care completed prior to initiation of services. **Denominator:** Total number of new participants.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of initial LOC determinations completed utilizing the approved waiver process. Numerator: The number of initial LOC determinations completed which utilized the approved waiver process. Denominator: The total number of initial LOC determinations completed.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of LOC determinations that were made correctly.

Numerator: The number of LOC determinations that were made correctly.

Denominator: The total number of participant LOC determinations reviewed.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

This data source captures data related to annual LOC reevaluations.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = <div> Confidence Interval=5% Confidence Level=95% </div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify: <div></div>	

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

This data source captures data related to initial LOC determination.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system to compile and calculate Level of Care performance measures for the CHOICES waiver. SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD review of compliance with LOC requirements including a one hundred percent quality assurance review of all initial LOC determinations made by the Office of Waiver Management QIDP or qualified DHS/DDD staff and a statistically valid sample of LOC reevaluations conducted by the Office of Waiver Management QIDP or qualified DHS/DDD staff. SMART aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvement. SMART engages DHS/DDD staff in remediation of problems discovered and systemic improvement of their LOC determinations. It is also available to DHS/DDD staff as a tool to generate individual specific reports to monitor and trend improvement progress.

The SMART system enables the DHS/DDD to query LOC performance data to monitor for systemic trends in compliance with LOC procedures. The Office of Waiver Management is responsible for conducting a one hundred percent quality assurance review of all LOC determinations. All LOC determinations are submitted to the Office of Waiver management for review to assure compliance with SSMA and waiver requirements. A statistically valid sample of LOC reevaluations conducted by the QIDP or qualified DHS/DDD staff are submitted to the Office of Waiver Management for review to assure compliance with SSMA and waiver requirements. Results from these reviews are entered into the SMART system. The Quality Assurance Manager is responsible for aggregating quarterly and annual data for systemic remediation by the SSMA and the IWRC. The SSMA and the IWRC monitors performance measures related to the accuracy of initial determinations as well as the timeliness of reevaluations. LOC determinations are made by the Office of Waiver Management QIDP or a qualified DHS/DDD staff who may request clinical consultation on difficult determinations. Reevaluations are completed by the DHS/DDD annually during the first quarter of the state fiscal year (between July and September each year). The reevaluations are made by a QIDP or qualified DDD staff.

The Core Stakeholders are also presented quarterly with the information related to each of the performance measures for review and analysis.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If it is discovered that a participant has received waiver services prior to an approved level of care the DHS/DDD will immediately ensure that any claims have been denied. The Office of Waiver Management will immediately ensure the completion of a LOC to determine the participant's eligibility status and conduct immediate training with the provider staff and the DHS/DDD staff. If the level of care determination indicates the person is not eligible for waiver services this information is sent to the SSMA. The SSMA provides the person with their right to appeal. The DHS/DDD provides the person and guardian or family information on available additional community resources.

The DHS/DDD completes all annual reevaluations for each waiver participant. This process is completed during July-September each year. If information is not received by the appropriate parties by the specified date, they are contacted and are provided a timeline of 3 business days to submit the information and the reevaluation is completed. The Waiver Administrator will provide training as necessary to ensure a full understanding of the necessity for timely information submission. If this results in a waiver participant no longer meeting eligibility criteria for the waiver this information is sent to the SSMA. The SSMA provides the person with their right to appeal. The person receives information from DHS/DDD on available resources.

The Office of Waiver Management conducts a quality assurance review of 100% of initial level of care determinations and enters the results into SMART. If an initial level of care determination, either approval or denial, is found to be incorrect according to SSMA or waiver requirements this is remediated on a case by case basis. The Office of Waiver Management's review also assures compliance with utilization of the approved waiver process including the use of required LOC criteria. The portion of the process incorrectly applied or inappropriate application of the LOC criteria is identified and immediately corrected. If this results in a waiver participant not meeting eligibility criteria for the waiver this information is sent to the SSMA. The SSMA provides the person with information regarding their right to appeal. The person is referred to additional community resources. Any payments that may have been made for waiver services will require claim adjustments be completed. If the process or application of the instrument resulted in a determination of ineligibility and the review shows the person is eligible, their LOC would be considered complete and they are immediately contacted and waiver services are started. The Waiver Administrator will provide additional training on a case by case basis to the Office of Waiver Management QIDP or qualified DHS/DDD staff who made the incorrect level of care determination.

The Office of Waiver Management completes a quality assurance review of annual reevaluations completed. This is completed using a 95% confidence level and 5% confidence interval for the total population of waiver recipients due for a LOC reevaluation. During the QA review the sample of LOC reevaluations are reviewed to ensure the appropriate redetermination was made by the DHS/DDD QIDP or qualified DHS/DDD staff. If a reevaluation decision, indicating the participant remains eligible, is found to be inaccurate and waiver participant is no longer eligible for waiver services the DHS/DDD notifies the SSMA immediately. The SSMA provides the person with information regarding their rights to appeal at that time. The DHS/DDD will assist in referring the person who has been redetermined to not be eligible for services to other community resources. If a reevaluation decision, indicating the participant is no longer eligible, is found to be inaccurate and the participant remains eligible for the waiver the DDD will notify the SSMA immediately. The SSMA will provide the participant information related to the reinstatement of their waiver services. The DHS/DDD will also contact the provider so they may also contact the participant. With each scenario, the Waiver Administrator will provide training to the DHS/DDD QIDP or qualified DHS/DDD staff who made the inaccurate decision and explain the reason for the inaccurate redetermination.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <div style="border: 1px solid black; padding: 2px; margin: 2px;">Internal Waiver Review Committee</div> <div style="border: 1px solid black; padding: 2px; margin: 2px;">Core Stakeholders Group</div>	
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Information about choice and rights of participants in the CHOICES waiver program is provided to applicants and their guardians and applicable advocate(s) and family members at the initiation of services. DHS/DDD has a Choice and Rights form, DHS-DD-717, which is used by case managers to inform applicants that services are available from either institutional or the Home and Community Based Services Waiver. The applicant is also provided with a list of all CHOICES waiver providers and services in South Dakota. This document explains HCBS to applicants and informs them that they have a right to appeal the decision of ineligibility if they are found ineligible for HCBS. A list of all CHOICES waiver providers and services in South Dakota is provided to the participant annually.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The participant's case manager maintains these records. A copy is retained at the DHS/DDD office.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Case managers will contract with interpreters to provide service to Limited English Proficient Persons who receive waiver services. All forms and materials will be translated to each person's language. Case managers will refer participants to English classes within each person's city to increase English proficiency. The DHS/DDD also has access to interpretation services to ensure meaningful conversations are able to be had with waiver participants, family members, and guardians of limited English proficient persons.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Career Exploration		
Statutory Service	Case Management		
Statutory Service	Day Services		
Statutory Service	Residential Habilitation		
Statutory Service	Supported Employment		
Other Service	Medical Equipment and Drugs		
Other Service	Nursing		
Other Service	Other Medically Related Services - Speech, Hearing & Language		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Career Exploration

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Services are based on the belief that all individuals with developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen field and explore new employment options as their skills, interests, and needs change. Career Exploration services are designed to assist participants in identifying and developing skills that prepare them for integrated competitive jobs and compensation at or above minimum wage, but not less than customary wage and level of benefits paid by the employer for similar work performed by employees without disabilities. Career Exploration services are limited to 18 months, with a maximum of two three-month extensions with approval by DHS. The outcome of this service is sustained paid employment and work experience to further career development and individual integrated community-based employment.

Career Exploration focuses on the development of competitive worker traits through the use of trial-work as the primary training method and teaches the understanding of the expectations of a competitive work environment, workplace problem solving skills and strategies, and general workplace safety and mobility training.

Career Exploration includes occupational training which is used to teach skills for the competitive labor market and includes personal training that is designed to develop appropriate worker traits and teach the understanding of the expectations of a work environment. The service also includes training on benefits management and other financial information needed by participants when they enter employment in the general workforce and work related evaluation which involves the use of planned activities, systematic observation, job shadowing, internships, and work trials to accomplish a formal assessment of the participant skills and interests, including identification of service needs and identification of employment objectives.

Participants receiving Career Exploration services must have an outcome for competitive integrated employment included in their person-centered ISP. Goals and supports related to employment must be outlined in the participant's person centered ISP, including activities designed to support such employment goals. Career Exploration can be furnished in a variety of locations in the community and are not limited to fixed-site facilities.

The DHS/DDD will preauthorize participant access to Career Exploration as well as requests for extension. Access and requests for extension must include ISP team determination of the person's interest in employment, existing work readiness skills and the length of time likely needed to transition successfully to Supported Employment. The DHS/DDD will determine through the preauthorization process if the supports identified by the ISP team are prevocational rather than vocational in nature.

Transportation between the participant's place of residence and the career exploration site is allowable and the cost of this transportation is included in the rate paid to providers of career exploration services.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Career exploration services are limited to 18 months, with a maximum of two three-month extensions with approval by DHS/DDD.

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Career Exploration****Provider Category:**

Agency

Provider Type:

Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications**License** (*specify*):

not applicable

Certificate (*specify*):

A CSP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD.

Other Standard (*specify*):

The provider shall ensure that all employees responsible for providing supports and services to individuals are trained on the minimum requirements necessary to address the individual's needs. The training and documentation requirements as described in 46:11:04:15.01.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDD is responsible to assure each CSP/OHCDS meets certification requirements pursuant to ARSD 46:11:02 and 46:11:04:15.01.

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Case Management

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Case Management services require the facilitation and development of a comprehensive person-centered individualized support plan (ISP) written by the case manager and reviewed by the state. Case managers provide ongoing monitoring of the participant's provision of services, health, welfare, and monitor the implementation of the participant's ISP at least quarterly. The plan is reviewed by the entire ISP team at least annually or more frequently as requested by the participant or as circumstances dictate. Case managers initiate a comprehensive assessment and periodic reassessment of individual needs to develop, revise and update the participant's ISP as well as advocate for the participant to exercise individual choice and independence. Case management services require the development of a 24-hour individual back-up plan with paid and natural supports. Case managers provide transition case management services to assist participants to transition from institutional settings to community settings by identifying needed waiver services, state plan services, as well as medical, social, housing, educational, non-paid natural supports, and other needed services, regardless of funding source. The costs of such services are considered to be incurred and billable when the person leaves the institutional setting and enters the waiver. The individual must be reasonably expected to be eligible for and to enroll in the waiver. If for any unseen reason, the individual does not enroll in the waiver (e.g., due to death or a significant change in condition), transitional services may be billed to Medicaid as an administrative cost. Case Management services cannot be delivered by the same provider of other waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transition case management services are limited to 60 days prior to the participant's transition to the CHOICES waiver from an institutional setting, unless otherwise agreed upon within the provisional plan of care approved by the DHS.

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Services Provider (SP) and Community Support Provider (CSP) /Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Case Management****Provider Category:**

Agency

Provider Type:

Community Services Provider (SP) and Community Support Provider (CSP) /Organized Health Care Delivery System (OHCDS)

Provider Qualifications**License** (*specify*):

Not Applicable

Certificate (*specify*):

A CSP/SP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) Article 46:11. The CSP/SP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD.

Other Standard (*specify*):

The provider shall ensure that all employees responsible for providing supports and services to individuals are trained on the minimum requirements necessary to address the individual's needs. The training and documentation requirements as described in 46:11:04:15.01.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDD is responsible to assure each CSP/SP/OHCDS meets certification requirements pursuant to ARSD 46:11 and 46:11:04:15.01..

Frequency of Verification:

Biennially

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Services shall be intended to assist the person to gain opportunities for meaningful life experiences in coordination with the person's personal goals and supports and agreed upon by the ISP team. Individuals in this service may not be paid a wage for activities in which they participate. Activities and environments are designed to:

- Build positive social relationships, interpersonal competence, greater independence and personal choice;
- Foster the acquisition of skills;
- Assist in maintaining skills and functioning and preventing or slowing regression for those with degenerative conditions;
- Empower the person to attain or maintain their highest level of self-determination;
- Occur in coordination with any physical, occupational, or speech therapies listed in the person-centered ISP;
- Include personal care/assistance, but these supports may not comprise the entirety of the service.

Day Services may be provided in integrated, community-based settings to promote volunteer activities that include acquiring, retaining, and improving self-help, socialization, and adaptive skills. Day Services settings may also be provided in fixed site facilities.

Day Services does not include compensation or the production of goods or services. Meals provided as part of Day Services shall not constitute a full nutritional regimen.

Transportation between the participant's place of residence and the Day Habilitation site is provided as a component of Day Habilitation services and the cost of this transportation is included in this rate.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not Applicable

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDs)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Day Services

Provider Category:

Agency

Provider Type:

Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDs)

Provider Qualifications**License** (*specify*):

not applicable

Certificate (*specify*):

A CSP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD.

Other Standard (*specify*):

The provider shall ensure that all employees responsible for providing supports and services to individuals are trained on the minimum requirements necessary to address the individual's needs. The training and documentation requirements as described in 46:11:04:15.01.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDD is responsible to assure each CSP/OHCDS meets certification requirements pursuant to ARSD 46:11:02 and 46:11:04:15.01.

Frequency of Verification:

Biennially

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):**HCBS Taxonomy:****Category 1:**

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2:

02 Round-the-Clock Services

Sub-Category 2:

02021 shared living, residential habilitation

Category 3:**Sub-Category 3:**

02 Round-the-Clock Services

02031 in-home residential habilitation

Service Definition (*Scope*):**Category 4:****Sub-Category 4:**

Residential Habilitation services are provided to participants living in their own home, which may include a group home, supervised apartment, or a Shared Living arrangement. Residential Habilitation services shall provide the participant with the opportunity to live as independently as possible, while ensuring for their safety. Services provided are assistance in acquiring, retaining, and improving skills related to activities of daily living, such as oral and personal hygiene, bathing, toileting, dressing, personal grooming and cleanliness, bed making, dusting, vacuuming, cleaning, laundry and housekeeping chores, simple home maintenance tasks, eating, cooking and the preparation of food, shopping, money management, budgeting, safety and self-help, recreation and socialization, and adaptive skills necessary for the person's health and welfare.

Also included is assistance in acquiring, retaining, and improving gross and fine motor skills, communication skills, and the reduction of maladaptive behavior.

Payments for Residential Habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of participants, or to meet the requirements of the applicable life safety code. Payments will not be made for the routine care and supervision which would be expected to be provided by a family (i.e., activities that would be performed ordinarily for an individual without a disability and/or chronic illness of the same age) or for activities or supervision for which a payment is made by a source other than Medicaid.

Transportation between the participant's place of residence and other service sites or places in the community is provided as a component of Residential Habilitation services and the cost of this transportation is included in this rate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not applicable

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDs)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Residential Habilitation****Provider Category:**

Agency

Provider Type:

Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications**License** (*specify*):

not applicable

Certificate (*specify*):

A CSP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD.

Other Standard (*specify*):

The provider shall ensure that all employees responsible for providing supports and services to individuals are trained on the minimum requirements necessary to address the individual's needs. The training and documentation requirements as described in 46:11:04:15.01.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHS/DDD is responsible to assure each CSP/OHCDS meets certification requirements pursuant to ARSD 46:11:02 and 46:04, if applicable, and 46:11:04:15.01.

Frequency of Verification:

Biennially

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Supported Employment

HCBS Taxonomy:**Category 1:**

03 Supported Employment

Sub-Category 1:

03021 ongoing supported employment, individual

Category 2:

03 Supported Employment

Sub-Category 2:

03022 ongoing supported employment, group

Category 3:**Sub-Category 3:**

☐
Service Definition (Scope):**Category 4:****Sub-Category 4:**

☐

Services are based on the belief that all individuals with developmental disabilities can work and that individuals of working age should be provided the supports necessary not only to gain and maintain employment but to advance in their chosen fields and explore new employment options as their skills, interests, and needs change. The outcome of the service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment services are supports to a participant or group of participants to obtain and maintain a job in integrated competitive employment, customized employment, or self-employment. Services include job coaching, job support, retention, and follow along. Participants may access Supported Employment regardless of whether Pre-Employment services have been previously accessed. Supported Employment is defined as:

- Integrated work setting in the general workforce.
- Compensation at or above the minimum wage for individual supported employment.
- Supported Employment can be provided to one individual or to a group of (2) to (8) individuals.
- Must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.
- Goals and/or supports related to employment are outlined within the person-centered ISP.

Participants receiving Supported Employment services must have an outcome for competitive, integrated employment included in their person-centered ISP. The service must be reviewed at least annually or more frequently as needed to assess the need for the service and progress on the employment outcome.

Transportation between the participant's place of residence and the employment site is allowable and the cost of this transportation is included in the rate paid to providers of supported employment services.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not Applicable

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Support Provider (CSP)/Organized Health Care Delivery System (OHCD)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License (*specify*):

Not Applicable

Certificate (*specify*):

A CSP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD.

Other Standard (*specify*):

The provider shall ensure that all employees responsible for providing supports and services to individuals are trained on the minimum requirements necessary to address the individual's needs. The training and documentation requirements as described in 46:11:04:15.01.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDD is responsible to assure each CSP/OHCDS meets certification requirements pursuant to ARSD 46:11:02 and 46:11:04:15.01.

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Medical Equipment and Drugs

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

14 Equipment, Technology, and Modifications

Sub-Category 3:

14010 personal emergency response system (PERS)

Service Definition (*Scope*):**Category 4:****Sub-Category 4:**

Medical equipment and drugs are devices, controls or appliances specified in the plan of care which enable participants to increase or maintain their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service can include designing, fitting, adapting, and maintaining equipment, as well as training or technical assistance to use equipment. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and items which are not of direct medical or remedial benefit to the participant are not covered. All items shall meet applicable standard of manufacture, design and installation. Drugs, chemicals, or preparations for the prevention, relief, or cure of diseases, including prescribed nutritional supplements that are not available under the State Plan are covered here.

The purchase or rent, repairs and maintenance of medical/adaptive equipment if not covered under warranty or by the Medicaid State Plan; payment of devices used when safety concerns exist, Lifeline services, Comfort One bracelets; and payment of any medications including over the counter medications and nutritional supplements not covered by Medicaid State Plan are allowable.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Non-allowable: assisting participants with taking their medications; Part D covered and Medicare excluded medications for dual eligibles; and Medicaid State Plan services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not Applicable

Service Delivery Method (*check each that applies*):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by** (*check each that applies*):**Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Medical Equipment and Drugs

Provider Category:

Agency

Provider Type:

Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License (*specify*):

Not Applicable

Certificate (*specify*):

A CSP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD.

Other Standard (*specify*):

The provider shall ensure that all employees responsible for providing supports and services to individuals are trained on the minimum requirements necessary to address the individual's needs. The training and documentation requirements as described in 46:11:04:15.01.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDD is responsible to assure each CSP/OHCDS meets certification requirements pursuant to ARSD 46:11:02 and 46:11:04:15.01.

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nursing

HCBS Taxonomy:**Category 1:**

05 Nursing

Sub-Category 1:

05010 private duty nursing

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Nursing services under the waiver differ in nature, scope and provider type from skilled nursing services in the State Plan. Services are listed in the plan of care which are within the scope of the South Dakota Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Services are limited to those nursing services which are not available under the Medicaid State Plan. Nursing services shall include screenings and assessments, nursing diagnosis, treatment, staff training for individuals who provide services to participants, scheduling medical appointments, monitoring of medical care and related services, providing health education/prevention, policy and procedure development and review and response to medical illnesses and emergencies.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not Applicable

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Support Provider (CSP)/Organized Health Care Delivery System (OHCD)

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service**Service Name: Nursing**

Provider Category:**Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:**HCBS Taxonomy:**

Category 1:

11 Other Health and Therapeutic Services

Sub-Category 1:

11010 health monitoring

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Implementation of direct therapies, treatment and services which are limited to those not available under the State Plan and are authorized by physicians, psychiatrists, physician assistants, licensed speech, physical and occupational therapists, pharmacists, optometrists, dentists and dental hygienists, audiologists, podiatrists, chiropractors, and dietitians. Services, therapies and treatments provided directly to the individual are indicated in the individualized services plan. Services will be furnished in an outpatient setting under the supervision of a registered nurse or licensed practical nurse, and will ensure the optimal functioning of the individuals.

Evaluation, program design, direct services, staff training, and policy and procedure review are allowable unless covered by the Medicaid State Plan. Communication programs and related services to improve general socialization skills are not allowable unless they are developed to reduce or eliminate certain undesired effects of a specific speech/language or hearing disorder.

Payment for dental, podiatry or dietician services not covered by Medicaid; pharmacy services - reviews of medication/potential drug interactions; and staff costs for following the guidance of physical therapists to provide restorative therapies are allowable.

Non-Allowable: assisting participants in attending doctor appointments; making sure food is a certain consistency; staff assistance to follow a difficult diet plan; and Medicaid State Plan services.

To the extent that any listed services are covered under the state plan, including EPSDT, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Not Applicable

Service Delivery Method (check each that applies):**Participant-directed as specified in Appendix E****Provider managed****Specify whether the service may be provided by (check each that applies):****Legally Responsible Person****Relative****Legal Guardian****Provider Specifications:**

Provider Category	Provider Type Title
Agency	Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Other Medically Related Services - Speech, Hearing & Language

Provider Category:

Agency

Provider Type:

Community Support Provider (CSP)/Organized Health Care Delivery System (OHCDS)

Provider Qualifications

License (*specify*):

Not Applicable

Certificate (*specify*):

A CSP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) 46:11:02. The CSP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD.

Other Standard (*specify*):

The CSP/OHCDS must provide Other Medically Related services under the supervision of a registered nurse or licensed practical nurse who is licensed to practice in South Dakota. The provider shall ensure that all employees responsible for providing supports and services to individuals are trained on the minimum requirements necessary to address the individual's needs. The training and documentation requirements as described in 46:11:04:15.01.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS/DDD is responsible to assure each CSP/OHCDS meets certification requirements pursuant to ARSD 46:11:02 and 46:11:04:15.01.

Frequency of Verification:

Biennially

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. Do not complete item C-1-c.

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

A CSP/SP/OHCDS must be certified by the DHS/DDD pursuant to Administrative Rules of South Dakota (ARSD) Article 46:11. The CSP/SP/OHCDS must be an enrolled Medicaid provider and have a provider agreement with DHS/DDD. Case Management services cannot be delivered by the same provider of other waiver services.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Each provider delivering services described in Appendix C must have a policy that addresses criminal background checks, felony convictions, and drug screenings for any new and current employees that provide direct service to participants. DHS/DDD recommends the utilization of the county clerk of courts system as it appears to be cost effective and time efficient. The DHS/DDD reviews a random sample of CSP/SP/OHCDS employees to ensure that criminal background checks have been completed. The DDD reviews a sample of CSP/SP/OHCDS employees, utilizing a 95% confidence level and a 5% confidence interval with a response distribution of 50%, to ensure that criminal background checks have been completed.

Providers that meet the requirements of SDCL 13-10-12 are exempt from this requirement. SDCL 13-10-12 addresses criminal background investigations of teachers and employees hired by school districts. Providers are required to apply the exclusions as outlined in the Social Security Act 1128, which addresses mandatory and permissive exclusions from programs receiving federal funding and includes the employment of a staff member who meets the exclusionary criteria.

Additionally, all employees are screened against the OIG exclusionary list as required by State Medicaid Director Letter #09-001.

- b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this

registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.

Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Community Residential Facilities	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Requirements for community residential facilities under the jurisdiction of DHS and those subject to §1616(e) of the Social Security Act are identified by Department of Health, Division of Health Systems Development and Regulation, Office of Health Facilities Licensure & Certification (OHFLC) utilizing the Life Safety Code Standards and standards within the American Disabilities Act. The OHFLC conducts inspections to determine compliance with safety, sanitation and physical facilities standards pursuant to ARSD 46:11:06:02, 46:11:06:09-46:11:06:14. Additional details can be found in Attachment #2 HCB Settings Waiver Transition Plan.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community Residential Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Supported Employment	

Waiver Service	Provided in Facility
Medical Equipment and Drugs	
Case Management	
Day Services	
Residential Habilitation	
Career Exploration	
Other Medically Related Services - Speech, Hearing & Language	
Nursing	

Facility Capacity Limit:

Not Applicable

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff:Resident ratios are monitored through certification surveys with standards for quality services and outcomes rather than specific staffing ratios.
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Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver

participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Self-directed

Agency-operated

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Pursuant to ARSD Article 67:54, to participate in the delivery of HCBS, providers shall be approved by DHS according to ARSD Article 46:11. Providers shall have a signed provider agreement with DHS and DSS. These agreements must be renewed annually.

Pursuant to ARSD Article 67:54, to receive reimbursement for covered medical services which are medically necessary and which are provided to eligible recipients, a provider must have a provider agreement with DSS. The agreement must be signed by the individual who is requesting to become a participating provider or by an agent of the facility or corporation that is requesting to become a participating provider and approved and signed by DSS. Only those individuals or facilities which meet licensure and certification requirements listed in this article may be participating providers.

A qualified provider of CHOICES waiver services is defined in SDCL 27B-1-17(3) Community Services Provider (SP) and 27B-1-17(4) Community Supports Provider (CSP). CSPs must be nonprofit corporations incorporated according to SDCL chapters 47-22 to 47-28, inclusive. CSPs must meet the definition for tax exemption status according to § 501(c)(3) of Title 26 of the Internal Revenue Code, October 22, 1986, as in effect on December 20, 1995. SPs may be non-profit or for profit organizations. The requirements for certification of CSPs and SPs are contained in ARSD Article 46:11.

Agencies seeking to become qualified providers of CHOICES waiver services may contact the Division of Developmental Disabilities to inquire about provider enrollment and receive instructions regarding the enrollment process. Additionally, the information governing provider enrollment is readily available on the DHS/DDD website. After all the required documentation described in 46:11:02:05.01 Enrollment requirements for providers, the DHS/DDD shall make a decision about issuing provisional certification status within 30 days.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of providers which continue to be in compliance with certification standards. Numerator: Number of existing providers that continue to

meet certification standards. Denominator: Total number of existing providers reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; padding: 5px;"> All providers will be reviewed in a two year period, 1/2 in one year and 1/2 the next year. </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

Performance Measure:

The number and percent of new provider applicants in compliance with state and federal requirements prior to delivery of services. Numerator: Number of new provider applicants that meet initial certification requirements prior to service delivery. Denominator: Total number of new provider applicants enrolled.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div></div>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of providers in compliance with training requirements.

Numerator: Number of providers in compliance with training requirements.

Denominator: Total number of providers reviewed.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify:

	Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> All providers will be reviewed in a two year period, 1/2 in one year and 1/2 the next year. </div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system to compile and calculate Qualified Provider performance measures for the CHOICES waiver. SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD review of compliance with Qualified Provider requirements including all certification standards and provider training. SMART aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvement. SMART engages qualified providers in the remediation of problems discovered and systemic improvement of their certification requirements. It is also available to DHS/DDD staff, the SSMA and qualified providers as a tool to generate agency specific reports to monitor and trend improvement progress.

The SMART system enables the DHS/DDD to query Qualified Provider performance data to monitor for systemic trends in compliance with Qualified Provider standards. The DHS/DDD is responsible for conducting a one hundred percent review of all new qualified providers and a biennial review is conducted for existing qualified providers in order to renew certification status. A statistically valid sample of participant files are reviewed on a continuous and ongoing basis while review of the provision of waiver services including compliance with ARSD/Waiver, compliance with provider agreements with both the SSMA and the DHS/DDD and good-standing accreditation by a national quality assurance organization are conducted biennially. The Quality Assurance Manager is responsible for aggregating quarterly and annual information for analysis by the Internal Waiver Review Committee (IWRC) and the Core Stakeholders Group. Their findings and recommendations are reported to the DDD Director and the SSMA for remediation.

The State does not have non-licensed/non-certified providers as a result there will not be any identified performance measures for B sub-assurance.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The primary discovery activities that have the potential to reveal individual problems related to the provision of services by qualified providers include complaint referrals to DHS/DDD, Biennial provider surveys, including Claims Review, National Core Indicator surveys, requests for administrative hearings, grievances, and public forums.

When an individual problem is discovered, DHS/DDD takes immediate action to assess, and if necessary, ensure the safety of the individual and other waiver participants. A DHS/DDD resource coordinator may be assigned to meet with the individual to gather information critical to resolving issues and problems. As merited by the situation, DHS/DDD may request additional information from the provider and/or conduct an onsite investigation. As appropriate, DHS/DDD may make a referral to Child Protective Services, Adult Services and Aging, Law Enforcement, and/or the Medicaid Fraud Control Unit. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions to include a plan of correction, probationary status and decertification.

The problem would be individually documented and systemically remediated through the discovery activity that revealed the problem. Additional information may be documented in the individual's file maintained by DHS/DDD.

Prior to delivering services, a provider is required to meet ARSD and Waiver assurances. Any deficiencies will be recorded by the DHS/DDD and the provider will be required to address prior to the delivery of any services. The DHS/DDD will continue to provide technical assistance during this process to ensure all requirements are met prior to certification.

If a provider is determined to not meet certification standards the provider would be subject to sanctions which may include probationary status to decertification. If a provider is placed on probationary status they are not allowed to enroll any new waiver participants without DHS/DDD approval. If a provider is decertified the DHS/DDD will assist waiver participants with transition to a new qualified provider of his/her choice.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> Internal Waiver Review Committee Core Stakeholders Group </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

The State currently does not have any non-licensed/non-certified providers of CHOICES waiver services. Over the course of the term of this approved waiver, the State will continuously examine and assess processes to monitor non-licensed/non-certified providers to assure the appropriate performance measures and processes are in place in the event participants would seek services from a non-licensed/non-certified provider.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will

be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Shared Living settings are residential settings where services are offered by a qualified provider that has round-the-clock responsibility for the health and welfare of residents, except during the time other services (e.g. supported employment services) are furnished. Shared Living settings are single family homes found in general integrated community settings. A shared living home may not serve more than two participants.

Shared Living is an arrangement in which an individual, or a family in the community, and a person with a disability choose to live together and share life's experiences. The home is owned by either the participant or their caregiver who has round-the-clock responsibility for the health and welfare of the participant. Shared Living settings are intended to maximize independence and safety, as well as supporting community access and integration. The shared living caregiver shall provide services, including assistance, support, and guidance, in life domain areas such as daily living, safety and security, community living, healthy lifestyle, social and spirituality, and citizenship and advocacy. The caregiver shall provide recreational and social activities outside of the home including individualized supports to the participant as specified in the participant's ISP.

Prior to the development of Shared Living settings, the DHS/DDD studied the federal regulation and guidance published by CMS and determined that an assessment of state policy and proposed Shared Living settings was necessary to ensure full compliance. The assessment was a combination of efforts used to determine if Shared Living settings would meet compliance, and if not, what needed to occur in order to achieve compliance prior to implementation. Assessment efforts included a review of other waiver program's Shared Living settings and policies, conversations with Shared Living and HCBS consultants, a thorough review of South Dakota laws and administrative rules, and public/stakeholder engagement and input. Assessment effort results were compared to the federal requirements. When compared to the federal requirements, the assessment results found that Shared Living settings are not congregate settings, do not isolate from the broader community, are not operated in or near the grounds of an institution and are owned by either the participant or an independent contractor chosen by the participant. Shared Living settings are not owned by a qualified provider. The assessment efforts also found Shared Living settings to meet the requirements of the federal regulation when Shared Living is delivered in accordance with state policies outlined in ARSD 46:04. ARSD 46:04 resulted from the assessment efforts and includes requirements for Shared Living settings to be in the community and delivered to promote relationship building and participant access to community as accessed by individuals without disabilities. To safeguard compliance, the DHS/DDD requires a letter of compliance prior to providing Shared Living to a participant. The DHS/DDD conducts an onsite biennial review of Shared Living settings to ensure ongoing compliance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individualized Service Plan (ISP)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The service plan development meeting shall be scheduled at least annually, or anytime at the request of the participant, and conducted in a manner which facilitates the active participation of the participant and the family, guardian, conservator, or advocate. The case manager shall encourage the participant to choose the location and members of the meeting and shall document if the participant is unable or unwilling to participate in the meeting.

The case manager shall provide support to each participant to actively engage in and direct the person-centered service plan development process. Prior to the service plan development meeting, the team members shall review all pertinent information, including assessments, any previous ISP developed another qualified provider, and a list of all qualified providers and the range of waiver services available, in terms of relevance to the participant's current needs and preferences.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The case manager is responsible for ISP development. The DHS/DDD allows for the use of a provisional service plan, as described in Appendix B, to get services initiated until a more detailed service plan can be finalized. The case manager and participant must identify an ISP development team within fifteen calendar days of initiation of services. The team must include the participant and the participant's case manager, and the following individuals shall have the opportunity to participate in the development of the service plan: the participant's parent if the participant is under 18 years of age, the participant's guardian or conservator if any, and any other individual desired by the participant. The case manager, the participant and the participant's team develop the ISP within thirty days of initiation of services. The ISP is implemented within forty-five days of initiation of services. The ISP team must meet at least annually to review the ISP; however the participant or any other member of the team may request an ISP team meeting at any time or as the participant's needs change. All ISP team meetings shall be scheduled and conducted in a manner which facilitates the active participation of all ISP team members, especially the participant and the family, guardian, conservator, adult foster care provider, or advocate. The case manager shall encourage the participant to choose the location of the meetings and shall document if the participant is unable or unwilling to participate in any meeting.

Prior to the initiation of services and at least annually thereafter, the participant and the identified ISP team shall review existing assessment information and complete new assessments or reassessments if appropriate. The initial and annual ISP shall include documentation of the results of the ISP team's review of the assessments. The assessments shall include: physical examination performed by a licensed physician or a specially trained physician's assistant or a nurse practitioner who is supervised by a licensed physician; dental examination; social evaluation; psychological evaluation by a qualified examiner; personal outcome assessment to identify and prioritize each participant's preferences; adaptive behavior or independent living skills; a developmental, educational or vocational evaluation; medication and immunization history; nutritional, vision, auditory, speech and language screenings; assistive technology assessment; and a safety assessment that addresses the participant's safety risks in the areas of environment, health, and personal vulnerability. The case manager shall complete an initial Inventory for Client and Agency Planning (ICAP) to assess the participant's functional limitations and identify corresponding need for services and will re-assess the participant's ICAP scores as needed. As appropriate, additional assessments may be conducted.

Initially and annually thereafter case managers will provide participants a choice of providers by providing a list of qualified providers and participants will also receive a list of the full range of CHOICES waiver services. Participants shall also receive information on how to request a fair hearing pursuant to ARSD Article 67:17 if choice of services or qualified provider is denied.

The ISP shall include the participant's goals including preferences and priorities; actions to be taken to attain the goals; and a personal outcome assessment to demonstrate how each participant's preferences are identified and prioritized. Each participant's ISP must be reviewed at least annually in terms of its relevance to the current needs of the participant. Each qualified provider is required to be accredited by a national quality assurance organization. The accreditation process will promote promising practices that shall ensure the ISP process addresses participant desired outcomes, needs and preferences.

The case manager shall be responsible for the oversight and monitoring of the ISP plan and shall complete the quarterly ISP assessment. The quarterly ISP assessment shall include information in the following areas:

- (1) The monitoring and coordinating of implementation of the ISP;
- (2) The observation and documentation of the ISP services;
- (3) Any intervention necessary to ensure the appropriate delivery of services and necessary revisions of the ISP;
- (4) Any review of substantiated instances of abuse, neglect, or exploitation;
- (5) Monitoring of the participant's health, welfare, and safety; and
- (6) Monitoring of the participant's progress toward goals or changes to the participant's health, safety, or behavior intervention plans.

The case manager shall provide the quarterly assessment to the ISP team and document the outcome of the review and any recommendations regarding the status of the ISP.

The participant, the participant's parent if the participant is under age 18, or the participant's guardian, if any, designates responsibility for implementing the service plan, and collaborates with the case manager to coordinate waiver and other State Plan services. That is, the participant and/or legal representative work with the case manager to coordinate State Plan Services with waiver services.

DHS/DDD provides oversight regarding the ISP development process, implementation and monitoring through the representative random sample review of participant records. In the event that a problem is discovered, the qualified provider is required to respond to the problem within 10 days of discovery. The DHS/DDD monitors the remediation efforts of the qualified provider until the problem is fixed.

The DHS/DDD participates in the National Core Indicators (NCI) project. As part of this survey, the DHS/DDD is able to obtain data on participant and family satisfaction of the ISP development process. Data gathered through the participation of NCI enhances the State's ability to monitor ISP development performance, incorporate the findings into decision making processes, and use the data in systemic quality improvement.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The case manager shall complete an initial ICAP and reassess ICAP scores for each participant at least annually. The ICAP assesses the participant's functional limitations and needed assistance. Risk factors address the areas of motor skills, social and communication skills, personal living skills, community living skills and maladaptive behaviors. If appropriate, other risk assessments such as a safety assessment that addresses the participant's safety risks in the areas of environment, health, and personal vulnerability are completed.

The participant and the participant's ISP team determine the amount of time, if any, that the participant may be at home without any supports. Supports must be provided when supervision of the participant is required. The ISP shall include documentation of the amount of time a participant can remain unsupervised. Each qualified provider shall deliver training in accessing on-call supports and emergency services to each participant.

The participant's case manager shall monitor the participant's health, safety and welfare in a manner that is sensitive to the participant's preferences. Each participant and the participant's team shall determine and document that the participant's living and work environments are safe. If unsafe conditions are identified, the team shall develop a plan which will immediately rectify the situation to ensure that the participant is safe.

Any critical services upon which the participant depends for health, welfare and safety are accompanied by a backup plan for provision of services when the qualified provider staff are unavailable. If the need for a backup plan is identified it is included within the ISP.

Pursuant to ARSD Article 46:11 each qualified provider must have a health, safety, sanitation, and disaster plan approved by the DDD. The plan must include specific procedures which ensure the health and safety of the participants at all times. Pursuant to ARSD Article 46:11, the participant's ISP team must determine and document the maximum amount of time, if any, the participant may be left unsupervised. A staff member must be on duty when supervision of the participant is required. Pursuant to ARSD Article 46:11 each qualified provider must have a policy which specifies how participants can access staff assistance when they are unsupervised. Assessment and training in accessing on-call staff and emergency services must be provided to each participant as indicated by each participant's needs and documented in the ISP. Policy is reviewed by the DDD initially and ongoing as changes are made to the policy. A representative random sample of participant records is reviewed for ISP documentation requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Participants are initially and annually thereafter informed by the participant's case manager of and acknowledge the right to freedom of choice of qualified providers that are available to furnish the services included in their ISP. Participants and their family and/or legal representatives are given a list of qualified providers of each waiver service in a manner consistent with their needs. The DHS-DDD-717 Form is signed by the participant and/or legal representative confirming qualified provider support in selecting providers is required initially. Annually thereafter the individual's case manager provides the participant and/or legal representative with a list of waiver services and qualified providers. The DDD monitors the implementation of this requirement through a 100% review of initial LOC determinations and through a representative random sample review of participant records.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

As described in Appendix A, the DHS/DDD (operating agency) and the DSS (Single State Medicaid Agency) have a MOU, signed by the Cabinet Secretary of each department, defining the responsibilities of each. The MOU indicates that the DSS shall monitor DHS/DDD operation of the CHOICES HCBS waiver program through review of DHS/DDD provider compliance reviews and Plans of Enhancement and review and approve/deny all administrative rule changes related participant ISP development.

Each quarter the DHS/DDD provides the SSMA with a SMART report, which contains the results of a review of a representative random sample of participant ISPs and any resulting qualified provider Plans of Enhancement, for review and approval. The SSMA has real time access to the SMART review system and all its components of the qualified provider quality assurance review process. This allows the SSMA the ability to monitor and review participant record findings, qualified provider findings, systemic reports and operating agency reports.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Pursuant to ARSD Article 46:11, each participant must have a designated case manager. The case manager conducts quarterly and annual reviews of each participant's ISP and may be contacted by a participant or their legal representative at any time to address changes. The case manager is also responsible for identifying issues/concerns with waiver or other services and supports the participant in taking appropriate action steps. If at any time a case manager believes that a participant's safety is at risk, the case manager will immediately rectify the situation to ensure the participant's safety. The participant's case manager is responsible for monitoring and coordinating the implementation of his/her ISP. The case manager shall be responsible to complete a quarterly ISP assessment. The quarterly ISP assessment shall include information in the following areas:

- (1) The monitoring and coordinating of implementation of the ISP including appropriate backup plans and access to non-waiver services;
- (2) The observation and documentation of the ISP services;
- (3) Any intervention necessary to ensure the appropriate delivery of services and necessary revisions of the ISP based on the participants needs;
- (4) Any review of substantiated instances of abuse, neglect, or exploitation;
- (5) Monitoring of the participant's health, welfare, and safety; and
- (6) Monitoring of the participant's progress toward goals or changes to the participant's health, safety, or behavior intervention plans.

The case manager shall provide the quarterly assessment to the ISP team and document the outcome of the review and any recommendations regarding the status of the ISP. The case manager shall ensure the participant acknowledges his/her right to exercise free choice of qualified providers of waiver services.

The DHS/DDD conducts a quality assurance review of a representative random sample of participant ISPs. The statistically valid sample is based upon a 95% confidence level, a 5% margin of error, and a response distribution based upon the results of the previous year's review cycle. When a participant's ISP is randomly selected for DHS/DDD quality assurance review, the case manager shall collect all information about ISP monitoring and implementation, including how problems identified during the monitoring were resolved, and submits the documentation to the DHS/DDD. All quality assurance review results are submitted to the SSMA for review and approval.

- b. Monitoring Safeguards.** *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participant ISPs that address participant needs.

Numerator: The number of participant ISPs which address the participant's assessed needs. Denominator: The total number of participant ISPs reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Level=95% Confidence Interval=5% </div>
Other	Annually	Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of participant ISPs that identify and address participant preferences and goals. Numerator: The number of participant ISPs that identify and address participant preferences and goals. Denominator: The total number of participant ISPs reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Level=95% Confidence Interval=5% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of participant ISPs that identify and address participant health and safety risk factors. **Numerator:** The number of participant ISPs that identify and address participant health and safety risk factors. **Denominator:** The total number of participant ISPs reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and	Other

	Ongoing	Specify: <div></div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

- b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participant ISPs that received a quarterly review by the case manager as required. Numerator: The number of participant ISPs that received a quarterly review by the case manager as required. Denominator: The total number of participant ISPs reviewed by the operating agency.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Level=95% Confidence Interval=5% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 250px; margin-top: 5px;"></div>

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participant ISPs that are revised when the needs of the participant have changed. Numerator: The number of participant ISPs that are revised when the needs of the participant have changed. Denominator: The total number of participant ISPs reviewed which require revision.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div> Confidence Level=95% Confidence Interval=5% </div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div> Sub-sample of representative sample (those participants who have experienced a change in need) </div>
	Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of participant ISPs that are updated annually. Numerator:
The number of participant ISPs that are updated annually. Denominator: The total number of participant ISPs reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participant ISPs delivered as specified in the participant's

ISP, including the type, scope, amount, duration and frequency. Numerator: The total number of participant ISPs delivered as specified in the participant's ISP. Denominator: The total number of participant ISPs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>95% confidence level; 5% confidence interval</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div>Proportionate sample; 95% confidence level; 5% confidence interval</div>
	Other Specify:	

	All providers will be reviewed in a two year period; 1/2 in one year and 1/2 in the next year.	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div></div>	Annually
	Continuously and Ongoing
	Other Specify: <div></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participants given choice between institutional care and waiver services at the time of initial LOC application. Numerator: The number of participants given choice between institutional care and waiver services at the time of application for waiver services as documented on the LOC application. Denominator: The total number of initial LOC applications reviewed.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

This data source captures data related to initial waiver level of care applications to ensure the participant was provided with choice of institutional care versus community based services.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

The number and percent of participants given the choice between qualified providers.

Numerator: The number of participants provided choice of qualified providers.

Denominator: The total number of participant records reviewed.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

This data source captures data related to initial waiver level of care applications to ensure the participant was provided with choice of qualified providers.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

This data source captures data related to participant files reviewed to ensure annually the participant was provided with choice of qualified providers.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> Confidence Level=95% Confidence Interval=5%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

The number and percent of participants provided the choice of waiver services.

Numerator: The number of participants provided choice of waiver services.

Denominator: The total number of participant records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

This data source captures data related to participant files reviewed to ensure annually the participant was provided with choice of waiver services.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
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State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Level=95% Confidence Interval=5% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

This data source captures data related to initial waiver level of care applications to ensure the participant was provided the choice of waiver services.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system to compile and calculate Participant-Centered Planning and Service Delivery performance measures for the CHOICES waiver. SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD review of compliance with Participant-Centered Planning and Service Delivery requirements including all components of service plan development and implementation. SMART aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvement. SMART engages qualified providers in the remediation of problems discovered and systemic improvement of their certification requirements. It is also available to DHS/DDD staff, the SSMA and qualified providers as a tool to generate agency specific reports to monitor and trend improvement progress.

The SMART system enables the DHS/DDD to query Participant-Centered Planning and Service Delivery performance data to monitor for systemic trends in compliance with participant safeguards standards. The DHS/DDD is responsible for conducting an offsite review of a statistically valid sample of participant files on a continuous and ongoing basis to assure the participant's needs are assessed, goals are identified, ISP is updated annually or as needed, services are delivered in accordance with the ISP, and choice of qualified providers and waiver services are provided at least annually. Individual problems discovered during the review must be fixed within a reasonable timeframe specified by the DHS/DDD. Systemic issues are addressed bi-annually through a qualified provider plan of enhancement process. The Quality Assurance Manager is responsible for aggregating quarterly and annual information for analysis by the Internal Waiver Review Committee (IWRC) and the Core Stakeholders Group. Their findings and recommendations are reported to the DDD Director and the SSMA for remediation.

Qualified providers are required to participate in a biennial billing onsite review process conducted by a DHS Management Analyst, in which a review is conducted on a proportionate random sample of participants' claims to ensure and validate the accuracy of record keeping, supporting documentation, and the resulting claims submitted for payment. Findings are compiled by the Office of Waiver Management and, if necessary, addressed in a plan of correction by the qualified provider, and summarized in a report issued to the qualified provider, the DDD/DHS Director and the SSMA.

The DHS/DDD participates in the National Core Indicator (NCI) survey to benchmark previous year's results and consider comparisons with other participating states. The DHS/DDD distributes the NCI report, posts it on the DHS/DDD web site, and conducts an analysis of the findings and develops necessary quality improvement system changes.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

ARSD Article 46:11 addresses a participant's needs, health and safety risk factors, personal preferences and goals as addressed in the ISP. If the ISP is found not to have addressed the participant's needs, not to have assessed and addressed the participant's health and safety, not to be reflective of the participant's personal preferences and goals, not to have used the approved process for service plan development, or not to have been monitored, the case manager has 10 days from the date of discovery to respond to the DHS/DDD indicating how the problem will be fixed. If the solution meets the approval of the DHS/DDD the case manager has 30 days from the date of discovery to reconvene the ISP team to update the ISP. If the problem takes longer than 30 days from the date of discovery to fix, the case manager must receive approval from the DHS/DDD for an extension and ensure the participant's health and safety are intact during the remediation process. Once the problem is fixed, the updated ISP is submitted to the DHS/DDD for approval. This entire process is documented in the SMART system and submitted to reports for trend analysis. If a significant amount of individual problems related to the participant's ISP surface during the DHS/DDD quality assurance review process, the case manager is required to submit a plan of enhancement to the DHS/DDD that address systemic level issues for DHS/DDD and SSMA approval. If at any point during this process it is discovered that the participant's health and safety are in immediate jeopardy, the DHS/DDD, and if necessary, in collaboration with other state agencies (i.e. the DHS Division of Long-Term Services and Supports, the DSS Child Protection Services, State Attorney's Medicaid Fraud Control Unit) and/or law enforcement, shall immediately conduct an onsite investigation to ensure participant safety. If the investigation substantiates the immediate health and safety of the participant, the qualified provider shall submit to the DHS/DDD a plan of correction and may be placed on probationary status, until the criteria of the plan of correction is met, or is decertified.

Pursuant to ARSD Article 46:11, if a participant's ISP is found not to be updated within 12 months of the previous ISP, found to not contain annual documentation of the choice of providers or choice of waiver services, or found not to be updated when the needs of the participant have changed, the case manager has 10 days from the date of discovery to respond to the DHS/DDD indicating how the problem will be fixed. If the solution meets the approval of the DHS/DDD the case manager has 30 days from the date of discovery to reconvene the ISP team to update the ISP or provide evidence that the problem has been fixed. If the problem takes longer than 30 days from the date of discovery to fix, the case manager must receive approval from the DHS/DDD for an extension and ensure the participant's health and safety are intact during the remediation process. Once the problem is fixed, the updated ISP or supporting documentation is submitted to the DHS/DDD for approval. This entire process is documented in the SMART system and submitted to reports for trend analysis. If a significant amount of individual problems related to the participant's ISP surface during the DHS/DDD quality assurance review process, the case manager is required to submit a plan of enhancement to the DHS/DDD that address systemic level issues for DHS/DDD and SSMA approval.

Per ARSD 67:16, qualified providers must keep legible medical and fiscal records that fully justify and disclose the extent of waiver services provided and the billings made to DHS. Per DHS Service Record Review Requirements, if it is determined that documentation maintained by the qualified provider is inadequate to support the activities reported in the participant's ISP (including type, scope, amount, duration and frequency), the participant's daily rate will be recalculated based on available documentation. If the participant's daily rate requires revision, the qualified provider will receive an adjusted consumer service authorization indicating the new daily rate and its associated effective dates. The qualified provider must submit a copy of the Medicaid remittance advice, indicating all claims during the review period were adjusted, to the DHS. The qualified provider must submit the required adjustments within 60 days from the receipt of the review report. If the qualified provider is not able to comply with the 60-day requirement, the provider must submit a written request for an extension to the DHS for consideration. The qualified provider must also submit any updates made to the participant's ISP to the DHS/DDD for review and approval. This entire process is documented in the SMART system and submitted to reports for trend analysis. If a significant amount of individual problems related to the participant's waiver services surface during the review, the qualified provider is required to submit a plan of enhancement to the DHS/DDD that addresses systemic level issues for DHS/DDD and SSMA approval.

The Office of Waiver Management will complete a 100% quality assurance review of initial LOC applications for participants new to the waiver. If it is determined that the choice of institution, choice of provider, or choice of waiver services are missing from a LOC the DHS/DDD will immediately notify the qualified provider request the documentation be submitted prior to the start of waiver services. The DHS/DDD will evaluate the LOC upon receipt of this information for compliance. The Waiver Administrator will conduct additional training with the Office of Waiver Management QIDP responsible for processing the LOC on LOC requirements.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px;"> Internal Waiver Review Committee Core Stakeholders Group </div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (2 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (3 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (4 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (5 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (6 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (7 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (8 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (9 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services**E-1: Overview (10 of 13)**

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

As described in Appendix B, the DHS-DD-717 Home and Community-Based Services Choice/Rights/Fair Hearings Form is a required component of the LOC application criteria.

Regarding Choice of Institutional Care, applicants are informed verbally by the case manager and in writing via the DHS-DD-717. The DHS-DD-717 Form provides information on how to request a fair hearing if not given the choice of Home and Community-Based Services as an alternative to institutional care and is signed by the applicant and/or legal representative and the case manager prior to the initiation of services. This form is maintained by the case manager and by the DHS/DDD. The applicant receives a written copy of the DHS-DD-717.

Regarding Choice of Services and Providers, applicants are informed verbally by the case manager and in writing via the DHS-DD-717 Form. The DHS-DD-717 Form provides information on how to request a fair hearing if denied a Home and Community-Based Waiver Service or denied the provider of choice and is signed by the applicant and/or legal representative and the case manager prior to the initiation of services. This form is maintained by the case manager and by the DHS/DDD. The DHS-DD-717 Form is accompanied with a listing all qualified waiver providers and waiver services. Annually, participants and/or legal representatives are provided in writing of their choice of qualified waiver providers and waiver services and the right to a fair hearing pursuant to ARSD Article 67:17 if choice of qualified waiver provider and waiver services is denied.

Regarding a Reduction or Termination of Services, documentation of the decision made by the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any, and the participant's team shall be included in the participant's file. Information about the fair hearing process must be provided at least ten days prior to the reduction of services when the reduction in services adversely affects the participant or the participant opposes the reduction in services. Information about the fair hearing process shall be provided to the participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian if any at least 30 days prior to the termination of services pursuant to ARSD Article 46:11. The participant shall continue receiving services during the appeal process until a decision is reached after a hearing pursuant to SDCL Chapter 1-26 unless to do so would pose a danger to the participant or others, in which case the qualified provider shall make alternative arrangements for the participant approved by the DHS/DDD. Additionally, the DHS-DD-717 Form provides information on how to request a fair hearing if the waiver participant feels that any of his or her rights have been violated or not honored in any way.

Regarding Timely Application Processing, Denial, Termination, participants/applicants are informed in writing by DSS via the DSS-EA-266 Notice of Action of their right to a fair hearing. This form is maintained electronically by DSS and a paper copy is maintained by the DHS/DDD. A copy is also provided to the applicant/participant, the participant's guardian/rep, and the provider.

The CHOICES waiver has no provision for suspension of services. Waiver services continue pending a fair hearing decision.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

All qualified providers are required to maintain a grievance/complaint system as specified in ARSD Article 46:11 which contains minimum procedures for grievance. A participant may register a grievance directly to the DHS/DDD as the state agency responsible for the operation of the grievance/complaint system at any time. If a grievance is registered directly with the state, several state agencies, including the DHS Long-Term Services and Supports, the DSS Child Protection Services, and the SD Medicaid Fraud Control Unit within the SD Attorney General's Office work collaboratively with the DHS/DDD whenever the need arises. All participants who file a grievance are afforded due process pursuant to South Dakota Codified Law Chapter 1-26.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each participant, the participant's parent if the participant is under 18 years of age, or the participant's guardian (also referred to in this section as the complainant) may register a grievance/complaint regarding any action or decision by the qualified provider which may adversely affect the provision of the participant's waiver services.

Each qualified provider must have written grievance procedures pursuant to ARSD Article 46:11 approved by the DHS/DDD whereby a participant, a participant's parent if the participant is under 18 years of age, or a participant's guardian is informed at the time of application and annually thereafter of their right to appeal any decision or action by the qualified provider that affects the participant. The qualified provider may not process a grievance until a participant has the opportunity to obtain an advocate if so desired. Advocates may not represent a participant in a grievance procedure unless requested by that participant and with the participant present. The qualified provider must ensure that assistance is provided for those who do not understand the grievance procedure.

At any time, a grievance/complaint may be submitted in writing, via e-mail or verbally to the DHS/DDD. Qualified Providers are required to provide participants initially and annually with information on how to contact the DHS/DDD. Participants seeking to file a grievance/complaint shall receive priority attention of available DHS/DDD staff. The DHS/DDD staff receiving the grievance/complaint should gather adequate information to assess the immediate safety of the participant(s) involved in the grievance/complaint. If the grievance/complaint involves the alleged abuse, neglect, or exploitation (ANE) of a person with intellectual/developmental disabilities, the first duty of the DHS/DDD staff person receiving the complaint is to take reasonable actions to ensure the health and safety of the person. DHS/DDD staff must ensure that any suspected illegal activity is reported to law enforcement and other appropriate state agencies.

A DHS/DDD Program Specialist shall contact the complainant within one (1) working day of receipt of all grievances/complaints to acknowledge receipt of the complaint/grievance. The DHS/DDD Program Specialist will gather information necessary to review the complaint/grievance. Information sources include but are not limited to qualified provider policies, qualified provider staff, people supported, guardians, individual files, etc. If the grievance/complaint involves medical or health issues the review should include an evaluation of a DHS/DDD Program Specialist who is also a registered nurse. If the complaint/grievance involves an allegation of ANE or the immediate jeopardy of the health and safety of the participant, the DHS/DDD Program Specialist should immediately notify a DHS/DDD supervisor and take reasonable actions to ensure the health and safety of the participant. The DHS/DDD Program Specialist should utilize available/applicable resources such as DHS/DDD management and nursing staff, state/federal laws, statements from parties involved, the implementation of the investigation process, etc. to make a determination on the complaint. The DHS/DDD Program Specialist will summarize the complaint, determination and any follow-up actions/resolution regarding the complaint and provide to a DHS/DDD supervisor for approval. This information will be provided to the complainant within 14 working days of the receipt of the complaint. If applicable, the DHS/DDD Program Specialist shall monitor the qualified provider action plan. A log of the complaint, including the timeline, summary and resolution, will be provided to the DHS/DDD Director, the SSMA and the Internal Waiver Review Committee for trend analysis.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an

appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All qualified providers as required in ARSD Article 46:11 must have a policy on abuse, neglect and exploitation, approved by DHS/DDD which:

- 1) Defines abuse, neglect and exploitation pursuant to SDCL 22-46-1;
- 2) Requires report to DHS/DDD pursuant to ARSD Article 46:11;
- 3) Requires report to DSS pursuant to SDCL 22-46, 26-8A-3 to 26-8A-8, inclusive;
- 4) Includes a procedure for an internal investigation, including the issuance of the investigation findings to the DHS/DDD within 30 calendar days and if allegation is substantiated, distribution of investigation results to the participant, the participant's parent if under 18 years of age, or the guardian, if any;
- 5) Includes a procedure for remediation to ensure health and safety of participants;
- 6) Includes a procedure for disciplinary action to be taken if staff has engaged in abusive, neglectful, or exploitative activities;
- 7) Includes a procedure to inform the guardian, the parent if the participant is under 18 years of age, and the participant's advocate if any of the alleged incident or allegation and any information not otherwise prohibited by court order about any action taken within 24 hours after the incident or allegation, unless the person is accused of the alleged incident;
- 8) Includes a requirement, upon substantiating the incident, to document the actions to be implemented to reduce the likelihood of or prevent repeated incidents of abuse, neglect or exploitation;
- 9) Includes a procedure for training provided in an accessible format to the participant, the guardian if any, and family members as identified by the participant upon admission and annually thereafter on how to report to the qualified provider and DHS/DDD any allegation of abuse, neglect, or exploitation; and
- 10) Includes a requirement that retaliation against a whistle blower is forbidden pursuant to SDCL 27B-8-43.

The critical events or incidents that qualified providers are required by ARSD Article 46:11 to report to DHS/DDD for review and follow-up action by the appropriate authority are:

1. Deaths;
2. Life-threatening illnesses or injuries;
3. Alleged instances of abuse, neglect, or exploitations against or by any participant;
4. Changes in health or behavior that may jeopardize continued services;
5. Serious medication errors;
6. Illnesses or injuries that resulted from unsafe or unsanitary conditions;
7. Any illegal activity involving a participant that involves law enforcement;
8. Any use of physical, mechanical, or chemical intervention that is not part of an approved plan;
9. Any bruise or injury resulting from the use of a physical, mechanical or chemical intervention; and
10. Any diagnosed case of a reportable communicable disease involving a participant.

The qualified provider must provide verbal notice of any critical event or incident to the DHS/DDD no later than the end of the next working day from the time the qualified provider becomes aware of the incident. The qualified provider must submit a written critical incident report utilizing the DHS/DDD online reporting system within seven (7) calendar days after the verbal notice is made. The written report must contain a description of the incident, specifying what happened, when it happened and where it happened. The report must also include any action taken by the qualified provider necessary to ensure the participant's safety and the safety of others and any preventative measures taken by the qualified provider to reduce the likelihood of similar incidents occurring in the future. Further information relating to the incident not available when the initial written report was completed may be submitted in the form of a follow-up to the online report. The DHS/DDD may request further information or follow-up related to the critical event.

South Dakota Senate Bill 14 was introduced during the 2011 Legislative session. SB 14 was drafted in collaboration with and supported by the Department of Health, the Department of Human Services, AARP, the Advisory Council on Aging, the Council of Mental Health Centers, Association of Community Based Services, the South Dakota Association of Healthcare Organizations, South Dakota Health Care Association and the Network Against Family Violence & Sexual Assault. SB 14 entitled an Act to require the mandatory reporting of abuse or neglect of elderly or disabled adults. With its passing, SB 14 amended SDCL Chapter 22-46 to establish a mandatory reporting system for abuse and neglect of elders or adults with disabilities similar to the mandatory reporting process that exists for child abuse.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or

families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Each qualified provider is required pursuant to ARSD Article 46:11 to provide each participant, any family members as identified by the participant, and the legal guardian if any with information or training in an accessible format regarding protection from abuse, neglect and exploitation which includes how to report incidents. This information will be provided at the time of admission and annually. The qualified provider must document the date, time, and content of this training. The DHS/DDD reviews this information for compliance of ARSD Article 46:11 during a representative random sample of review of participant records.

Each qualified provider is required to add the following statement to each participant's ISP that informs each participant/family/guardian/advocate how to contact the DHS/DDD if they have concerns or would like to self-report an incident. "I understand that if I have any questions, comments, or concerns about my services, I can contact a program specialist at the Division of Developmental Disabilities, c/o 500 East Capitol, Pierre, SD 57501. Toll free in SD: 1-800-265-9684 or (605) 773-3438. Email info: <http://dhs.sd.gov/developmentaldisabilities/default.aspx>

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Upon receiving the written report of a critical event required by ARSD Article 46:11, the DHS/DDD Program Specialist will conduct a review of the report within two (2) working days if due to abuse, neglect, exploitation and death, or within five (5) working days if related to any other incident-type described in G-1b. to ensure appropriate reporting/notification as described above; if indicated by the MOU with the Attorney General, forward the report to the Medicaid Fraud Control Unit (MFCU); conduct follow up with collaborating state agencies as described above; assess the current situation to ensure the health, welfare and safety of the participant; assess the qualified provider's investigation of the incident; and conduct further review of the incident if determined that the qualified provider is not compliant with any provision of ARSD and waiver requirements. Any incident that involves alleged abuse, neglect or exploitation of a participant by a qualified provider staff person, is reported to MFCU for potential investigation and prosecution as appropriate. Pursuant to ARSD 46:11:03:01 Provider policy on abuse, neglect, and exploitation a provider shall have a policy approved by the DHS/DDD containing the follow procedures for an internal investigation: (a) Initiation of the investigation within 48 hours or the next business day, whichever is later; (b) Issuance of preliminary investigation findings to the division within seven calendar days of initiation of the investigation; (c) Issuance of the final investigation findings to the DHS/DDD within 30 calendar days of initiation of the investigation.

The DHS/DDD conducts internal and external quality assurance reviews of all critical incidents. One hundred percent of incidents received by DHS/DDD are reviewed by a DHS/DDD Program Specialist. The DHS/DDD Program Specialist assigned to the qualified provider receives the critical incident report and conducts the initial review. The DHS/DDD Quality Assurance Manager reviews a representative random sample of the critical incident reports. The DHS/DDD Quality Assurance Manager reviews each critical incident report to ensure that all reporting requirements were met and assess if appropriate follow-up was taken by the DHS/DDD Program Specialist and provider. Recommendations are provided to the provider's assigned Program Specialist as appropriate.

For purposes of ensuring compliance with certification, the DHS/DDD may survey the qualified provider at any given time without prior notice pursuant to ARSD Article 46:11. The DHS/DDD may impose probation, not to exceed one year, if a qualified provider has deficiencies which seriously affect the health, safety, welfare, or rights of a participant pursuant to ARSD Article 46:11. The qualified provider must complete, in a period approved by DHS/DDD, but not to exceed 1 year, a plan of corrective action approved by DHS/DDD pursuant to ARSD Article 46:11. All relevant parties are notified in writing of the results of an investigation within 15 days of the completion of an investigation.

A qualified provider's certification may be revoked pursuant to ARSD Article 46:11 on any of the following grounds: 1) Permitting, aiding, or abetting the commission of any unlawful act; 2) Engaging in any practices which seriously affects the health safety, welfare, rights, or habilitation of the participants; 3) Failure to comply with all licensing and other standards required by federal or state laws, rules, or regulations that result in practices which are detrimental to the welfare of the participants; 4) Falsifying information provided to the DHS/DDD for certification purposes; or 5) Failure to comply with a probationary plan of corrective action.

The Internal Waiver Review Committee is comprised of the each state waiver manager as well as representatives from the SSMA and the DHS Budget and Finance Office. The Core Stakeholders Group is comprised of participants, participant family members, qualified provider staff, non-profit disability organizations, and other state agency staff. The Internal Waiver Review Committee and the DDD Advisory Group will conduct an external review of critical incidents to identify trends and areas of concerns and provide recommendations to the DHS/DDD.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS/DDD conducts annual ARSD/HCBS participant record review that is a representative, random sample of all waiver participant service plans. The statistically valid sample size is based upon historical data from the previous annual ARSD/HCBS participant record review cycle. The sample size is derived by using a sample size calculator that takes into account the margin of error, the confidence level, the population size and the response distribution of previous review cycle results. This review process ensures that reportable incidents not reported pursuant to ARSD Article 46:11 or that reported incidents not in compliance of ARSD Article 46:11 are discovered and remediated. Any discovery of noncompliance in these areas will result in the qualified provider creating and submitting a Plan of Enhancement to the DHS/DDD for review, approval and continued monitoring.

The DHS/DDD Quality Assurance Manager compiles and analyzes aggregate data from the CIR reporting process to identify red flags for further follow up and trends that may indicate training needs and/or service enhancements on a quarterly basis. Quarterly data is presented to the Internal Waiver Review Committee and the DDD Advisory Group to provide oversight of critical incidents received by DHS/DDD and work with DHS/DDD to identify how this oversight is conducted to be beneficial to participants, providers and DHS/DDD.

All qualified providers must meet the certification requirements set forth in ARSD 46:11. DHS notifies the SSMA when and why a provider is placed on probation, when a provider satisfactorily completes a probationary plan of corrective action and/or when and why a provider's certification is revoked.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The use of restraints may be applied only if a person with an intellectual/developmental disability exhibits destructive behavior and if alternative techniques including positive behavior support techniques have failed.

South Dakota Codified Law 27B-8-50 Aversive behavioral techniques --Findings. The Legislature hereby finds that:

- 1) Research does not support the long-term efficacy of aversive behavioral intervention;
- 2) The use of aversive or abusive treatment raises disturbing legal and ethical issues, and may well deprive the recipient of constitutional or statutory rights and be outside the ethical guidelines imposed upon the treatment professional;
- 3) Any person with a disability has the same right to be treated with dignity and respect as any other citizen; and
- 4) The use of aversive and abusive treatments on any person with a disability diminishes the dignity and humanity of the treatment professional and the person with a disability.

The South Dakota Legislature opposes any treatment or practice which violates the right to freedom from harm. The South Dakota Legislature promotes activities that lead to implementation and dissemination of positive intervention alternatives.

The use of aversive intervention techniques is prohibited. No person may use aversive intervention techniques on a person with an intellectual/developmental disability. The rights of any person with an intellectual/developmental disability receiving services may only be restricted as a result of due process in accordance with statute and the rules of the South Dakota Department of Human Services. The rights of any person with an intellectual/developmental disability may be suspended to protect that person from endangering self or others. In order to provide specific services or supports to the person with an intellectual/developmental disability, such rights may be suspended only by due process that will promote the least restriction on the person's rights.

The use of any highly restrictive procedures, including restraints and time-out, shall be described in written behavior support plans. Use of restraints shall be applied only in an emergency if alternative techniques have failed. Physical restraint intended to restrict the movement or normal functioning of a portion of a person's body through direct contact by staff, shall be employed only if necessary to protect the person with an intellectual/developmental disability from immediate injury to self or others. No physical restraint may be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports. Physical restraint shall be applied only after alternative techniques have failed and only if such restraint is imposed in the least possible restriction consistent with its purpose. Mechanical restraint using mechanical devices intended to restrict the movement or normal functioning of a portion of a person's body is subject to special review and oversight, as defined in rules promulgated pursuant to South Dakota Codified Law Chapter 1-26. Any mechanical restraint shall be designed and used so as not to cause physical injury to the person with an intellectual/developmental disability and so as to cause the least possible discomfort. No chemical restraint and medication may be used excessively, as punishment, for the convenience of staff, as a substitute for a program, or in quantities that interfere with a person's developmental program.

In accordance with statute and the rules promulgated pursuant to SDCL Chapter 1-26, due process shall be assured pursuant to SDCL § 27B-8-52 for the use of physical, mechanical, or chemical restraints, including their use in an emergency or on a continuing basis.

A behavior support plan is designed to increase the participant's socially adaptive behaviors and to modify the participant's maladaptive or challenging behaviors. The outcome is to replace maladaptive or challenging behaviors with behaviors and skills that are adaptive and socially productive. A behavior support plan shall use, develop, and promote positive, respectful approaches for teaching in every aspect of life. Behavior support plans may only be implemented following the completion of a comprehensive functional analysis if alternative nonrestrictive procedures have been proven to be ineffective, and only with the informed consent of the person with an intellectual/developmental disability, if eighteen years of age or over and capable of giving informed consent, or the person's parent or legal guardian. Behavior support plans shall be developed in conjunction with the interdisciplinary team and implemented in accordance with South Dakota Codified Law § 27B-8-52.

Time-out procedures used for separating a person with an intellectual/developmental disability from other

persons receiving services and group activities may be employed only under close and direct staff supervision and only as a technique in behavior support plans. Time-outs may not be used in an emergency situation. Behavior support plans utilizing a time-out procedure may be implemented only if it incorporates a positive approach designed to result in the acquisition of appropriate behavior.

Each qualified provider of direct HCB services must have a human rights committee or participate in a multiagency committee pursuant to ARSD Article 46:11 which ensures that each participant's rights are supported. The committee's membership is appointed and selected by the qualified provider and its composition must meet the following criteria:

- (1) Committee membership must include at least one participant or a participant's representative;
- (2) At least one-third of the committee's members may not be affiliated with the qualified provider; and
- (3) At least one member of the committee must have training or experience with issues and decisions regarding human rights.

The human rights committee must use the following procedures:

- (1) Review and approve or disapprove all behavior support plans which use any highly restrictive procedures listed in ARSD Article 46:11. The review must ensure the opportunity for the informed consent of and participation by the participant, the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any, or advocate in the development of highly restrictive supports;
- (2) Review and approve or disapprove at least every six months all behavior support plans which use any highly restrictive procedures listed in ARSD 46:11;
- (3) Review each participant's restrictions of rights and restoration plan;
- (4) Review and approve the qualified provider's policies, procedures, and practices in limiting rights of participants; and
- (5) Provide the committee with training in individual rights, disability awareness, and the qualified provider's philosophy and mission.

Each qualified provider of direct HCB services must have policies approved by the DHS/DDD addressing the use of highly restrictive procedures. Such procedures include physical or chemical intervention, medications to manage behavior, time-outs, or other techniques with similar degrees of restriction or intrusion. The policy shall include:

- (1) Procedures to ensure compliance with SDCL 27B-8-51, 27B-8-52, 27B-8-54, and 27B-8-55;
- (2) A description of the ISP team's process including plan development, identifying the most appropriate restrictive procedure for the participant's needs and restoration plan, and consent by the participant, or the participant parent, if the participant is under 18 years of age, or the participant's guardian, if any;
- (3) Procedures for review, approval, and right to appeal, the highly restrictive procedures by the participant, or the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any;
- (4) A review and approval by the human rights committee and behavior support committee prior to implementation and at least every six months thereafter;
- (5) A description of circumstances under which a time-out may be used, the maximum time it may be used, and the procedures to be followed;
- (6) A requirement that the participant's plan include timelines for notifying the participant's parent, if the participant is under 18 years of age, or the guardian, if any, when highly restrictive procedures are used;
- (7) A requirement to address emergency rights restrictions, including time-lines of team meetings and review by the human rights committee and the behavior support committee; and
- (8) Procedures to ensure regular oversight of implementation and staff training.

Each qualified provider of direct HCB services must have a behavior support committee pursuant to ARSD Article 46:11, that is appointed and selected by the qualified provider, which reviews the technical adequacy of and approves all behavior support plans which use any highly restrictive procedures listed in ARSD Article 46:11.

The behavior support committee must be composed of a person with experience or training regarding behavior support and a physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications to manage behavior. The behavior support committee must be provided with training in the effectiveness of behavior support techniques, the qualified provider's mission and philosophy, behavior changing medication, and disability awareness.

The participant's case manager will review and approve all rights restrictions.

ARSD Article 46:11 A time-out refers to a highly restrictive procedure in which the participant is denied egress from an enclosed area when exhibiting a problem behavior. A time-out may only be used under continuous observation of the participant by a qualified provider staff, may not take place in a room that can be locked with a key, and must allow for immediate staff entry. A time-out may only be used as part of a behavior support plan approved by both the qualified provider's human rights and behavior support committees. A time-out may not be used in a punitive fashion. Each use of the time-out may not exceed 15 minutes. If after 15 minutes, the participant continues to exhibit a maladaptive behavior that poses a threat to the participant or others, the use of the time-out may continue for another 15 minutes. The maximum amount of time a participant may be in a time-out shall not exceed one continuous hour. The qualified provider shall document any use of the time-out room.

The individual service plan of a participant who exhibits maladaptive behavior must include provisions to teach the participant the circumstances, if any, under which the behavior can be exhibited adaptively; to teach the participant how to channel the behavior into similar but adaptive expressions; or to replace the behavior with behavior that is adaptive.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The DHS/DDD is responsible for general oversight and monitoring the use of highly restrictive procedures, including restraints and time-out, used by qualified providers. DHS/DDD will review the use of highly restrictive procedures through an ARSD/HCBS quality assurance review of the qualified provider's policies specified in § 46:11. Biennially the DHS/DDD will review the implementation of the requirements specified in ARSD Article 46:11 regarding the Behavior Support Committee, and Human Rights Committee composition, and procedures of the provider of direct HCB services. The DHS/DDD will conduct a review of a representative random sample of participant files which shall include a review of any restraint procedure and behavior support plan used by the qualified provider.

The DHS/DDD prohibits the use of seclusion.

The DHS/DDD also completes internal investigations upon receipt of a concern or complaint from participants, family members, guardians, and/or community members regarding highly restrictive procedures.

DHS/DDD's incident reporting database will also be used to identify any unauthorized use, over use or inappropriate use of highly restrictive procedures and follow-up will occur as appropriate.

If applicable, the DHS/DDD will collaborate with other state agencies, such as the Department of Social Services Child Protection Agency, the Department of Human Services, Division of Long Term Services and Supports (LTSS), or the Attorney General's Medicaid Fraud Control Unit, to investigate the use of highly restrictive procedures that are not, or suspected to not be, in compliance with due process and the requirements specified in South Dakota Codified Law or Administrative Rules of South Dakota.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

--

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Unless modified by court order, a person with an intellectual/developmental disability has the same legal rights and responsibilities guaranteed to all other persons under the federal and state constitutions and federal and state laws. No person with an intellectual/developmental disability may be required to perform any act or is subject to any procedure which is contrary to the person's religious beliefs, and each person has the right to practice personal religious beliefs and to be accorded the opportunity for religious worship. No person may be coerced into engaging in or refraining from any religious activity, practice, or belief. Any person with an intellectual/developmental disability has the right to receive publicly supported educational services in accordance with federal and state education laws. Any person with an intellectual/developmental disability has the right to access to appropriate dental and medical care and treatment for any physical ailments and for the prevention of illness or disability. Surgery and any other medical procedures may be performed without consent or court order only if the life of the person with an intellectual/developmental disability is threatened and there is not time to obtain consent or a court order. Documentation of the necessity for the surgery shall be entered into the record of the person as soon as practicable. No person with an intellectual/developmental disability is subject to any experimental research or hazardous treatment procedures without the consent of:

- (1) The person with an intellectual/developmental disability, if eighteen years of age or over and capable of giving informed consent. If any person's capacity to give informed consent is challenged, the person, a qualified intellectual disability professional, physician, or interested person may file a petition with the court to determine competency to give consent;
- (2) The guardian of the person with an intellectual/developmental disability, if the guardian is legally empowered to execute such consent; or
- (3) The parent or guardian of the person with an intellectual/developmental disability, if the person with an intellectual/developmental disability is less than eighteen years of age.

No person with an intellectual/developmental disability who is subject to an order of guardianship may be subjected to experimental research or hazardous treatment procedures without prior authorization of the circuit court.

The receipt of services and supports pursuant SDCL Chapter 27B-8 does not operate to deprive any person with an intellectual/developmental disability of any other rights, benefits, or privileges, does not cause the person with an intellectual/developmental disability to be declared legally incompetent, and may not be construed to interfere with the rights and privileges of parents or guardians regarding the minor child. No agency, community service provider, facility, school, or person who receives public funds and provides services to persons with intellectual/developmental disabilities may engage in the following practices:

- (1) Corporal punishment--physical or verbal abuse, such as shaking, screaming, swearing, name calling, or any other activity that would be damaging to a person's physical well-being or self-respect; and
- (2) Denial of food--preventing a person from having access to a nutritionally adequate diet as a means of modifying behavior. Persons enrolled in residential programs or living units are expected to partake in meals at a predetermined scheduled time.

Any person with an intellectual/developmental disability receiving services has the right to:

- (1) Communicate freely and privately with others of the person's own choosing;
- (2) Receive and send sealed, unopened correspondence. No person's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;
- (3) Receive and send packages. No person's outgoing packages may be opened, delayed, held, or censored by any person;
- (4) Reasonable access to telephones, both to make and to receive calls in privacy, and reasonable and frequent opportunities to meet with visitors; and
- (5) Suitable opportunities for interaction with others of the person's own choosing.

No person may use aversive intervention techniques on a person with an intellectual/developmental disability. The rights of any person with an intellectual/developmental disability receiving services may only be restricted as a result of due process in accordance with statute and the rules of the Department of Human Services. The rights of any person with an intellectual/developmental disability as specified in this chapter may be suspended to protect that person from endangering self or others. In order to provide specific services or supports to the person with an intellectual/developmental disability, such rights may be suspended only by due process that will promote the least restriction on the person's rights.

Pursuant to ARSD Article 46:11 the rights of the participant may only be restricted to protect the consumer from endangering self or others or to provide specific services or supports as provided in SDCL 27B-8-52. Any restriction of rights shall promote the least restrictive alternative appropriate to meet the needs of the participant. Prior to restricting a participant's rights, the qualified provider shall require the participant, the participant's ISP team the participant's parent, if the participant is under 18 years of age or the participant's

guardian, to review and approve each restriction. The qualified provider's human rights committee shall act as an impartial party to review and approve or deny each restriction prior to implementation and at least annually thereafter. If the participant displays behavior that endangers self or others and requires an emergency rights restriction, the qualified provider shall notify the human rights committee and the participant's parent if the participant is under 18 years of age or the legal guardian within 24 hours of implementation of the restriction. The participant's case manager will be an active participant on Human Rights Committee.

The human rights committee must use the following procedures:

- (1) Review and approve or disapprove all behavior support plans which use any highly restrictive procedures listed in ARSD Article 46:11. The review must ensure the opportunity for the informed consent of and participation by the participant, the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any, or advocate in the development of highly restrictive supports;
- (2) Review and approve or disapprove at least every six months all behavior support plans which use any highly restrictive procedures listed in ARSD Article 46:11;
- (3) Review each participant's restrictions of rights and restoration plan;
- (4) Review and approve the qualified provider's policies, procedures, and practices in limiting rights of participants; and
- (5) Provide the committee with training in individual rights, disability awareness, and the qualified provider's philosophy and mission.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The DHS/DDD is responsible for general oversight and monitoring the use of highly restrictive procedures, including restraints and time-out, used by qualified providers of direct HCB services. DHS/DDD will review the use of highly restrictive procedures through an ARSD/HCBS quality assurance review of the qualified provider's policies specified in § 46:11. Biennially the DHS/DDD will review the implementation of the requirements specified in ARSD Article 46:11 regarding the Behavior Support Committee, and Human Rights Committee composition, and procedures of the provider of direct HCB services. The DHS/DDD will conduct a review of a representative random sample of participant files which shall include a review of any restraint procedure and behavior support plan used by the The use of restraints may be applied only if a person with an intellectual/developmental disability exhibits destructive behavior and if alternative techniques including positive behavior support techniques have failed.

South Dakota Codified Law 27B-8-50 Aversive behavioral techniques --Findings. The Legislature hereby finds that:

- 1) Research does not support the long-term efficacy of aversive behavioral intervention;
- 2) The use of aversive or abusive treatment raises disturbing legal and ethical issues, and may well deprive the recipient of constitutional or statutory rights and be outside the ethical guidelines imposed upon the treatment professional;
- 3) Any person with a disability has the same right to be treated with dignity and respect as any other citizen; and
- 4) The use of aversive and abusive treatments on any person with a disability diminishes the dignity and humanity of the treatment professional and the person with a disability.

The South Dakota Legislature opposes any treatment or practice which violates the right to freedom from harm. The South Dakota Legislature promotes activities that lead to implementation and dissemination of positive intervention alternatives.

The use of aversive intervention techniques is prohibited. No person may use aversive intervention techniques on a person with an intellectual/developmental disability. The rights of any person with an intellectual/developmental disability receiving services may only be restricted as a result of due process in accordance with statute and the rules of the South Dakota Department of Human Services. The rights of any person with an intellectual/developmental disability may be suspended to protect that person from endangering self or others. In order to provide specific services or supports to the person with an intellectual/developmental disability, such rights may be suspended only by due process that will promote the least restriction on the person's rights.

The use of any highly restrictive procedures, including restraints and time-out, shall be described in written behavior support plans. Use of restraints shall be applied only in an emergency if alternative techniques have failed. Physical restraint intended to restrict the movement or normal functioning of a portion of a person's body through direct contact by staff, shall be employed only if necessary to protect the person with an intellectual/developmental disability from immediate injury to self or others. No physical restraint may be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports. Physical restraint shall be applied only after alternative techniques have failed and only if such restraint is imposed in the least possible restriction consistent with its purpose. Mechanical restraint using mechanical devices intended to restrict the movement or normal functioning of a portion of a person's body is subject to special review and oversight, as defined in rules promulgated pursuant to South Dakota Codified Law Chapter 1-26. Any mechanical restraint shall be designed and used so as not to cause physical injury to the person with an intellectual/developmental disability and so as to cause the least possible discomfort. No chemical restraint and medication may be used as punishment, for the convenience of staff, as a substitute for a program, or in quantities that interfere with a person's developmental program.

In accordance with statute and the rules promulgated pursuant to SDCL Chapter 1-26, due process shall be assured pursuant to SDCL § 27B-8-52 for the use of physical, mechanical, or chemical restraints, including their use in an emergency or on a continuing basis.

A behavior support plan is designed to increase the participant's socially adaptive behaviors and to modify the participant's maladaptive or challenging behaviors. The outcome is to replace maladaptive or challenging behaviors with behaviors and skills that are adaptive and socially productive. A behavior support plan shall use, develop, and promote positive, respectful approaches for teaching in every aspect of life. Behavior

support plans may only be implemented following the completion of a comprehensive functional analysis if alternative nonrestrictive procedures have been proven to be ineffective, and only with the informed consent of the person with an intellectual/developmental disability, if eighteen years of age or over and capable of giving informed consent, or the person's parent or legal guardian. Behavior support plans shall be developed in conjunction with the interdisciplinary team and implemented in accordance with South Dakota Codified Law § 27B-8-52.

Time-out procedures used for separating a person with an intellectual/developmental disability from other persons receiving services and group activities may be employed only under close and direct staff supervision and only as a technique in behavior support plans. Time-out procedures may not be used for emergency situations does not include involuntary confinement of a person alone in a room. Behavior support plans utilizing a time-out procedure may be implemented only if it incorporates a positive approach designed to result in the acquisition of appropriate behavior. The state reviews a representative random sample of participant files to ensure time out is not used for emergency purposes, is incorporated into a positive behavior support plan and is approved by the participant's team, the human rights committee and behavior support committee prior to use.

Each qualified provider of direct HCB services must have a human rights committee or participate in a multiagency committee pursuant to ARSD Article 46:11 which ensures that each participant's rights are supported. The committee's membership is appointed and selected by the qualified provider and its composition must meet the following criteria:

- (1) Committee membership must include at least one participant or a participant's representative;
- (2) At least one-third of the committee's members may not be affiliated with the qualified provider; and
- (3) At least one member of the committee must have training or experience with issues and decisions regarding human rights.

The human rights committee must use the following procedures:

- (1) Review and approve or disapprove all behavior support plans which use any highly restrictive procedures listed in ARSD Article 46:11. The review must ensure the opportunity for the informed consent of and participation by the participant, the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any, or advocate in the development of highly restrictive supports;
- (2) Review and approve or disapprove at least every six months all behavior support plans which use any highly restrictive procedures listed in ARSD 46:11;
- (3) Review each participant's restrictions of rights and restoration plan;
- (4) Review and approve the qualified provider's policies, procedures, and practices in limiting rights of participants; and
- (5) Provide the committee with training in individual rights, disability awareness, and the qualified provider's philosophy and mission.

Each qualified provider of direct HCB services must have policies approved by the DHS/DDD addressing the use of highly restrictive procedures. Such procedures include physical or chemical intervention, medications to manage behavior, time-out, or other techniques with similar degrees of restriction or intrusion. The policy shall include:

- (1) Procedures to ensure compliance with SDCL 27B-8-51, 27B-8-52, 27B-8-54, and 27B-8-55;
- (2) A description of the ISP team's process including plan development, identifying the most appropriate restrictive procedure for the participant's needs and restoration plan, and consent by the participant, or the participant parent, if the participant is under 18 years of age, or the participant's guardian, if any;
- (3) Procedures for review, approval, and right to appeal, the highly restrictive procedures by the participant, or the participant's parent, if the participant is under 18 years of age, or the participant's guardian, if any;
- (4) A review and approval by the human rights committee and behavior support committee prior to implementation and at least every six months thereafter;
- (5) A description of circumstances under which a time-out room may be used, the maximum time it may be used, and the procedures to be followed;
- (6) A requirement that the participant's plan include timelines for notifying the participant's parent, if the participant is under 18 years of age, or the guardian, if any, when highly restrictive procedures are used;
- (7) A requirement to address emergency rights restrictions, including time-lines of team meetings and review by the human rights committee and the behavior support committee; and
- (8) Procedures to ensure regular oversight of implementation and staff training.

Each qualified provider of direct HCB services must have a behavior support committee pursuant to ARSD Article 46:11, that is appointed and selected by the qualified provider, which reviews the technical adequacy of and approves all behavior support plans which use any highly restrictive procedures listed in ARSD Article 46:11.

The behavior support committee must be composed of a person with experience or training regarding behavior support and a physician, pharmacist, or other professional qualified to evaluate proposals for the use of medications to manage behavior. The behavior support committee must be provided with training in the effectiveness of behavior support techniques, the qualified provider's mission and philosophy, behavior changing medication, and disability awareness.

The participant's case manager will review and approve all rights restrictions.

ARSD Article 46:11 refers to a time-out as a highly restrictive procedure in which the participant is denied egress from an enclosed area when exhibiting a problem behavior. A time-out may only be used under continuous observation of the participant by a qualified provider staff, may not occur in a room that can be locked with a key, and must allow for immediate staff entry. A time-out may only be used as part of a behavior support plan approved by both the qualified provider's human rights and behavior support committees. A time-out may not be used in a punitive fashion. Each use of a time-out may not exceed 15 minutes. If after 15 minutes, the participant continues to exhibit a maladaptive behavior that poses a threat to the participant or others, the use of the time-out may continue for another 15 minutes. The maximum amount of time a participant may be in the time-out shall not exceed one continuous hour. The CSP shall document any use of the time-out..

The individual service plan of a consumer who exhibits maladaptive behavior must include provisions to teach the consumer the circumstances, if any, under which the behavior can be exhibited adaptively; to teach the consumer how to channel the behavior into similar but adaptive expressions; or to replace the behavior with behavior that is adaptive.

The DHS/DDD prohibits the use of seclusion.

The DHS/DDD also completes internal investigations upon receipt of a concern or complaint from participants, family members, guardians, and/or community members regarding highly restrictive procedures.

DHS/DDD's incident reporting database will also be used to identify any unauthorized use, over use or inappropriate use of highly restrictive procedures and follow-up will occur as appropriate.

If applicable, the DHS/DDD will collaborate with other state agencies, such as the Department of Social Services Child Protection Agency, the DHS Division of Long-Term Services and Supports, or the Attorney General's Medicaid Fraud Control Unit, to investigate the use of highly restrictive procedures that are not, or suspected to not be, in compliance with due process and the requirements specified in South Dakota Codified Law or Administrative Rules of South Dakota.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this

oversight is conducted and its frequency:

The DHS/DDD prohibits the use of seclusion. The DHS/DDD is responsible for general oversight and monitoring the use of highly restrictive procedures, including restraints and time-out, used by qualified providers of direct HCB services. DHS/DDD will review the use of highly restrictive procedures through an ARSD/HCBS quality assurance review of the qualified provider's policies specified in § 46:11. Biennially the DHS/DDD will review the implementation of the requirements specified in ARSD Article 46:11 regarding the qualified provider's Behavior Support Committee, and Human Rights Committee composition, and procedures. The DHS/DDD will conduct a review of a representative random sample of participant files which shall include a review of any restrictive procedure and behavior support plan used by the qualified provider.

The DHS/DDD also completes internal investigations upon receipt of a concern or complaint from participants, family members, guardians, and/or community members regarding highly restrictive procedures.

DHS/DDD's incident reporting database will also be used to identify any unauthorized use, over use or inappropriate use of highly restrictive procedures and follow-up will occur as appropriate.

If applicable, the DHS/DDD will collaborate with other state agencies, such as the Department of Social Services Child Protection Agency, the DHS Division of Long-Term Services and Supports, or the Attorney General's Medicaid Fraud Control Unit, to investigate the use of highly restrictive procedures that are not, or suspected to not be, in compliance with due process and the requirements specified in South Dakota Codified Law or Administrative Rules of South Dakota.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

- b. Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The qualified provider is responsible for second-line monitoring of participant medication regimens. The qualified provider, under the delegation and supervision of a Board of Nursing licensed nurse, shall assist the participant in obtaining blood levels at least annually or as recommended by the participant's physician related to specific medications or diagnosis. The qualified provider shall assist the participant with obtaining follow-up medical care related to any non-therapeutic levels.

In addition to assisting the participant in obtaining blood levels at least annually or as recommended by the participant's physician related to specific medications or diagnosis, each qualified provider provides a minimum of 20 hours of medication administration training to its employees, including academic instruction and practical application. This training must be conducted under the supervision of a licensed registered nurse. The content of the training for medication administration must address these areas:

- 1) General information relevant to the administration of medications including governmental regulations and legalities, ethical issues, terminology, forms of medication, procedures and routes of medication administration, and medication references;
- 2) An overview of major categories of medications as related to body systems and basic principles of drug therapy;
- 3) Additional instruction, including those categories of medications related to the specific needs of the consumers that the staff will be assisting;
- 4) Limitations of the staff administering medications;
- 5) Legal responsibilities to the consumers, the nurse, and the qualified provider;
- 6) Reporting observations for the well-being of the consumer, including potential side effects and adverse reactions to medications;
- 7) The CSP's policy and procedures regarding its medication system, including storage;
- 8) Assistance with safe and accurate self-administration or administration of medications; and
- 9) Reporting of medication administration errors.

The training may also include the areas of first aid, cardiopulmonary resuscitation, infection control, and communicable diseases. Each qualified provider shall have employees demonstrate proficiency in medication administration before administering medication or assisting with self-administration of medication. The required level of proficiency in medication administration is obtaining a score of at least 90 percent through a written examination and demonstrating clinical proficiency on a performance checklist. Each qualified provider shall maintain documentation of an employee's training and proficiency level in the employee's personnel file. Employees completing the medication administration training are subject at least annually to a proficiency review supervised by a licensed registered nurse. The qualified provider shall maintain documentation of annual evaluations of an employee's proficiency in the employee's personnel file. The DDD provides oversight to qualified providers regarding medication management and administration through ongoing ARSD/HCBS reviews. The Legislature gave the DDD authority in SDCL 27B-2-26 to allow qualified providers to administer medications.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The DHS/DDD is responsible for general oversight and monitoring of qualified providers regarding medication management. The DHS/DDD will conduct a review of a representative random sample of waiver participant files utilizing a 95% confidence interval and 5% margin of error which shall include a review of medication management procedures used by the qualified provider, including the completion of obtaining timely participant blood levels, the documentation of participant blood levels, and appropriate follow-up of non-therapeutic levels.

In addition to the monitoring of the qualified provider assistance in the participant in obtaining blood levels at least annually or as recommended by the participant's physician related to specific medications or diagnosis, the DDD provides oversight through the monitoring of critical incident reports related to medications. The DDD employs two registered nurses who assist with this oversight. In 2008, nurses from qualified providers developed a statewide medication administration training curriculum aimed to improve quality and consistency. This curriculum, used by all qualified providers, discusses ARSD pertaining to medication management and administration, ethical and legal issues, medical terminology and abbreviations, routes of medication administration, forms of medication, medication classifications, medication reference materials, body systems, examples of diagnoses, medications that may be used to treat a condition, learning to observe for changes in physical health and/or behavior, reporting changes, the essential rights of safe medication administration, additional rights, self-administration risks and responsibilities, and risks of medication administration.

The DDD ARSD/HCBS ongoing participant record review includes a DDD registered nurse who reviews self-administration and medication management requirements. The DDD registered nurse also conducts observations of CSP staff administering medications during each biennial onsite review. Each qualified provider provides oversight within the agency by a registered nurse. The DDD reviews and approves each qualified provider's policy regarding medication administration to participants. The DDD reviews the policies initially and ongoing as changes to the policies are made. The DDD also conducts a sample review of qualified provider employees' personnel files to ensure that appropriate competency-based training has occurred.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

Not applicable. *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each qualified provider must assess initially and annually thereafter the participant's ability to self-administer medications.

Each qualified provider shall provide medication administration training to employees, including academic instruction and practical application. This training must be conducted under the supervision of a licensed registered nurse. The content of the training for medication administration shall be in accordance with ARSD Article § 20:48. A qualified provider employee must demonstrate proficiency in medication administration required by ARSD 46:11:07:08 before administering medication or assisting with self-administration of medication to participants. The qualified provider shall maintain documentation of an employee's training and proficiency level in the employee's personnel file. Qualified provider employees completing the medication administration training are subject at least annually to a proficiency review that is supervised by a licensed registered nurse. The qualified provider shall maintain documentation of annual evaluations of an employee's proficiency in the employee's personnel file.

Any employee hired by a qualified provider after February 1, 1996, whose duties include the administration of medications or assistance with self-administration of medications, must be a high school graduate or possesses a general equivalency diploma.

Any employee who has received prior medication administration training from another qualified provider must provide documentation with proof of prior training and demonstrate the level of proficiency required by § 46:11:07:08.

iii. Medication Error Reporting. *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

All serious medication errors are reported to the DHS/DDD. Medication errors involving abuse, neglect, or exploitation shall also be reported to the DHS Division of Long-Term Services and Supports, the DSS Child Protective Services, and/or the Attorney General's Medicaid Fraud Control Unit.

(b) Specify the types of medication errors that providers are required to *record*:

Each qualified provider must have policies and procedures that address medication errors. The policies and procedures shall address these areas:

- (1) A definition of medication error;
- (2) The types or severity of medication errors;
- (3) Documentation of all medication errors;
- (4) Action to be taken as a result of medication errors;
- (5) A process for on-going quality assurance and monitoring of medication errors; and
- (6) Prevention of medication errors.

(c) Specify the types of medication errors that providers must *report* to the state:

Qualified providers are required to report to DHS/DDD all serious medication errors. A serious medication error is the inappropriate administration of a medication to the participant by a qualified provider that results in emergency medical treatment, hospitalization, or death.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The DHS/DDD is responsible for monitoring the performance of qualified providers in the administration of medications to waiver participants. The DHS/DDD will review and approve all qualified provider policies regarding medication self-administration and medication administration curriculum specified in ARSD Chapter § 46:11:07 Health Care Services. This review is conducted initially and ongoing if/when updates to the policies are made by the qualified provider. Biennially the DHS/DDD nurse will review the qualified provider's implementation of the requirements specified in § 46:11:07 Health Care Services.

The DDD utilizes an online reporting system for Critical Incident Reporting (CIR) that allows qualified providers to submit required reports electronically and allows the DDD to analyze data. The qualified provider is required to submit a CIR involving serious medication errors. A serious medication error is the inappropriate administration of a medication that results in emergency medical treatment, hospitalization, or death. The DDD collects quarterly data and reviews trends by provider and CIR category. A root cause analysis process is used to determine areas of concern that might benefit from changes in policy and practice. A root cause analysis is a process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence of a sentinel event. As trends are identified, DDD Program Specialists are responsible for addressing issues with their assigned qualified provider. Medication errors that do not meet CIR criteria must be documented internally by the qualified provider. The qualified provider will maintain a system to collect and analyze data regarding medication errors, including the implementation of preventative measures. The qualified provider is required to collect and document at least annually findings of the data analysis.

Through the use of person-centered practices, each qualified provider assesses the participant's specific needs and designs individualized supports with each individual who desires to administer their own medication. ARSD §46:11:07:05 defines self-administration as the act of assisting a participant with one or more steps in the process of taking medications, but not actual administration of medications. Assistance with self-administration of medications may include opening the medication container, reminding the participant of the proper time to take the medication, helping to remove the medication from the container, and returning the medication container to storage. Pursuant to ARSD §46:11:07:06 each qualified provider is required to have a self-administration policy to address the assessment of a participant's ability to self-administer medications. The level of assistance that the participant requires regarding medication administration must be determined by the participant and the participant's service team and assessed annually. DDD reviews the policy initially and ongoing as changes are made to the policy. The implementation of the policy is reviewed during biennial onsite ARSD/HCBS reviews and entered into the SMART system. SMART produces meaningful information from qualified provider compliance reviews for the CHOICES Waiver Administrator to trend and analyze self-administration data for systemic improvement.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participants for whom an allegation of ANE was reported, investigated, and was appropriately followed up as required. Numerator: The number of participant files reviewed in which an allegation of ANE was reported, investigated, and appropriately followed up as required. **Denominator:** The total number of participant files reviewed with an allegation of ANE.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Level=95% Confidence Interval=5% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

Number and percent of participants trained on ANE reporting. Numerator: The number of participant files reviewed in which the participant received training on ANE reporting. **Denominator:** The total number of participant files reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Level=95% Confidence Interval=5% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

The number and percent of participant files in which the participant's medications were appropriately monitored. Numerator: The total number of participant files in which the participant was assisted in obtaining blood levels at least annually or as needed related to specific medications or diagnoses. Denominator: The total number of participant files reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> Confidence Interval = 5% Confidence Level 95% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px; margin-top: 10px;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 10px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 240px; margin-top: 10px;"></div>

Performance Measure:

The number and percent of participants whose self-administration of medications needs are assessed and addressed as required. Numerator: The number of participant files reviewed in which the participant's self-administration of medication needs are assessed and addressed according to operating agency requirements. Denominator: The total number of participant files reviewed.

Data Source (Select one):**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Interval = 5% Confidence Level = 95% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

Performance Measure:

The number and percent of participants for whom critical incidents not related to ANE were reported and followed up appropriately as required. Numerator: The number of participant files reviewed in which a critical incident not ANE related was reported timely and included CSP follow up actions as required. Denominator: The total number of participant files reviewed with CIRs not related to ANE.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div>Confidence Level=95% Confidence Interval=5%</div>
Other Specify: <div></div>	Annually	Stratified Describe Group: <div></div>
	Continuously and Ongoing	Other Specify: <div></div>
	Other Specify:	

	<input type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of participant records in which all critical incidents were addressed.

Numerator - Number of participant records reviewed in which all critical incidents were addressed/Denominator - Total number of participant records reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Level=95% Confidence Interval=5% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participants free from inappropriate restraint.

Numerator: The number of participant files reviewed in which the participant is free from inappropriate restraint. **Denominator:** The total number of participant files reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence

		Interval = Confidence Interval = 5% Confidence Level= 95%
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The number and percent of participants who received assistance in obtaining health care evaluations consistent with the ACS and immunizations as recommended by the most current available Immunization Schedule from the CDC. Numerator: The number of participant files reviewed in which preventative health standards met.

Denominator: The total number of participant files reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Confidence Interval = 5% Confidence Level = 95% </div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 120px;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system to compile and calculate Health & Welfare performance measures for the CHOICES waiver. SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD review of compliance with Health & Welfare requirements including all critical incident reporting, medication management and administration and the use of highly restrictive procedures. SMART aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvement. SMART engages qualified providers in the remediation of problems discovered and systemic improvement of their certification requirements. It is also available to DHS/DDD staff, the SSMA and qualified providers as a tool to generate qualified provider specific reports to monitor and trend improvement progress.

The SMART system enables the DHS/DDD to query Health & Welfare performance data to monitor for systemic trends in compliance with participant safeguards standards. The DHS/DDD is responsible for conducting a one hundred percent review of all qualified provider policies and a biennial onsite review is conducted for the review of the implementation of policies. A statistically valid sample of participant files is reviewed on a continuous and ongoing basis to assure participant's health and welfare. Individual problems discovered during the review must be fixed within a reasonable timeframe specified by the DHS/DDD. Systemic issues are addressed biennially through a qualified provider plan of enhancement process. The Quality Assurance Manager is responsible for aggregating quarterly and annual information for analysis by the Internal Waiver Review Committee (IWRC) and the DDD Advisory Group. Their findings and recommendations are reported to the DDD Director and the SSMA for remediation.

The DHS/DDD participates in the National Core Indicators (NCI) survey to benchmark previous years' results and consider comparisons with other participating states. The DHS/DDD distributes the NCI report, posts it on the DHS/DDD web site, and conducts an analysis of the findings and develops necessary quality improvement system changes.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The primary discovery activities that have the potential to reveal individual issues related to participant health and welfare include complaint referrals to DHS/DDD, Biennial provider surveys, National Core Indicator surveys, Critical Incident Reporting (CIR) System, participant file reviews, and public forums.

When an individual problem is discovered, DHS/DDD takes immediate action to assess, and if necessary, ensure the safety of the individual and other waiver participants. A DHS/DDD resource coordinator may be assigned to meet with the individual to gather information critical to resolving issues and problems. As merited by the situation, DHS/DDD may request additional information from the provider and/or conduct an onsite investigation. As appropriate, DHS/DDD may make a referral to Child Protective Services, Adult Services and Aging, Law Enforcement, and/or the Medicaid Fraud Control Unit. Issues that pose a serious threat to health or safety or demonstrate continued failure to meet state requirements can result in provider sanctions to include a plan of correction, probationary status and decertification.

The problem would be individually documented and systemically remediated through the discovery activity that revealed the problem. Additional information may be documented in the participant's file maintained by DHS/DDD.

During review of waiver participant files the DHS/DDD Program Specialist ensures that:

- (1) Each waiver participant has been provided training on reporting ANE;
- (2) Allegations of ANE are handled appropriately according to operating agency policy;
- (3) Critical incidents not related to ANE are handled appropriately according to operating agency policy; and
- (4) Participants are free from inappropriate restraint.

During review of waiver participant files the DHS/DDD Registered Nurse ensures that:

- (1) Participant medications are appropriately monitored; and
- (2) Participant self-administration needs are assessed and addressed

If it is discovered that any of these requirements are missing or inadequate, the qualified provider is required within 10 days to develop and submit a plan of remediation to the DHS/DDD which includes the timeframe to resolve the issue. If the problem takes longer than 30 days from the date of discovery to fix, the qualified provider must receive approval from the DHS/DDD for an extension and ensure the participant's health and safety are intact during the remediation process. Once the problem is fixed, supporting documentation is submitted to the DHS/DDD for approval. This entire process is documented in the SMART system and submitted to reports for trend analysis. If a significant amount of individual problems related to the participant's health or welfare surface during the DHS/DDD quality assurance review process, the qualified provider is required to submit a plan of enhancement to the DHS/DDD that address systemic level issues for DHS/DDD and SSMA approval.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: Internal Waiver Review Committee Core Stakeholders Group	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	<div data-bbox="815 215 1241 300" style="border: 1px solid black; height: 38px; width: 267px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The waiver's operating agency is responsible for data analysis and remediation information from the quality improvement system. The operating agency is also responsible for trending the data and providing information to the SSMA. Together the operating agency and the SSMA determine system improvements or changes that may be needed. This communication facilitates ongoing discovery and remediation. The operating agency is responsible for implementation of system improvements and changes. This includes updates to both internal and external stakeholders, tracking systems changes, and potentially amending the waiver with changes to, or addition of, performance measures.

In addition to the SSMA, the operating agency also utilizes other waiver partners for assistance with data analysis, review of trended information, and development of potential system improvements. These partners include the Core Stakeholders Groups and the Internal Waiver Review Committee (IWRC). The DHS/DDD solicits input from a wide cross-section of interested parties within our ID/DD system called the Core Stakeholders Group. The Core Stakeholders Groups is comprised of a wide variety of stakeholder work groups which include community members, waiver participants and their families, provider personnel, DHS and DDD personnel, and other partners within the state. On a quarterly basis the DHS/DDD Advisory Group, comprised of representatives of the Core Stakeholders Group, come together to discuss statewide ID/DD infrastructures, trends occurring in the field, issues that require attention and any other items that seek to progress our efforts in achieving our mission. The IWRC consists of the waiver managers (and if appropriate a back-up waiver manager) from each of the four DHS waivers (Family Support, CHOICES, ADLS, and HOPE) and a designee of the SSMA. The committee meets quarterly to review and analyze data gathered for the quality improvement strategy of each respective waiver. The committee makes recommendations and plans for systems improvement. If necessary, the operating agency may also bring together additional groups of stakeholders if significant issues are identified within the waiver operation.

Data related to the operation of the waiver is received, documented, and maintained by the Waiver Administrator. Data sources currently include CHOICES Waiver tracking systems, SMART system, biennial review of qualified providers, and critical incident reporting. The data collected is then recorded in the appropriate databases and spreadsheets for analysis and trending. If necessary, any immediate remediation is completed at this time. The analyzed/trended data, and any remediation completed, is reviewed by the operating agency and SSMA to identify any additional areas that may need attention. The DHS/DDD Advisory Group and IWRC are also utilized to review the data analysis, completed remediation, and recommendations for further enhancements. Once further enhancement plans are developed, these will be shared with internal and external stakeholders.

The State continually reviews the SMART system to determine if the design remains functional or if changes and improvements to the SMART system are required.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div>Internal Waiver Review Committee Core Stakeholders Group</div>	Other Specify: <div></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The monitoring of the effectiveness of the waiver quality improvement strategies is continuous and ongoing. The initial steps to ensure quality begin with the qualified provider properly implementing ARSD and waiver assurances. The next steps are quality reviews conducted by state officials to ensure compliance with ARSD and waiver assurances. The final step in the quality assurance process is the role of the Waiver Administrator who has the primary responsibility of the waiver. The Waiver Administrator is responsible for the administration of the waiver, implementation of the quality improvement strategies, and assessment of the effectiveness of system design changes. The Waiver Administrator provides this information to the DHS/DDD Director, the SSMA and other partners for assistance with remediation and potential changes to the quality improvement strategies. If changes are determined necessary the operating agency will design the changes. The Waiver Administrator will implement the changes and the Quality Assurance Manager will collect and analyze the data to determine if the system changes were successful. Effectiveness of the changes will be determined by data indicating a positive or negative change in the overall discovery data. The analysis will be presented to the DHS/DDD Director, the Internal Waiver Review Committee and the Core Stakeholders Group for continued trending. Any enhancement plans developed as a result of trending analysis will be shared with internal and external stakeholders through issuance of Policy Memorandums.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Information vital to the success of the waiver is gathered through many forms: SMART system, critical incident reporting, biennial provider reviews, and waiver tracking systems. This information is directly related to the waiver's quality improvement system. The quality improvement system is evaluated by the Quality Assurance Manager at each juncture of the continuous quality improvement cycle:

Design;
Discovery;
Remediation;
Implementation/Improvement.

This continuous cycle will provide the avenue necessary to determine the effectiveness of the quality system. If the quality system is not effective this will be apparent through repeated issues and problems. These will be the indicators of the necessity for changes to the quality system. The DHS/DDD administration, Core Stakeholders Group, Internal Waiver Review Committee, and other stakeholders will play a vital role in the development of improvements to the quality strategy. At a minimum all aspects of the quality improvement system will be reviewed annually to review the collected and analyzed data. If analysis shows a need for system improvements prior to an annual review this will be completed as described in H.1.a.i and H.1.b.i.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Qualified providers are required to:

- 1) Conduct and submit an annual independent audit;*
- 2) Undergo a representative random sample review of all claims; and*
- 3) Submit to monitoring conducted by DHS as a component of the Payment Error Rate Measurement (PERM).*

According to the contractual arrangement with qualified waiver providers, each provider is required to undergo and submit an annual, entity-wide audit conducted by an independent, third party audit firm in accordance with generally accepted accounting principles. These audits are received, reviewed and analyzed by DHS fiscal staff. Issues/concerns are reported to DHS/DDD for follow-up.

Qualified providers are required to participate in an onsite billing review process conducted by a DHS analyst, in which a review is conducted on a proportionate random sample of participants' claims to ensure and validate the accuracy of record keeping, supporting documentation, and the resulting claims submitted for payment. For the purposes of calculating a statistically valid sample size, a 5% margin of error, a 95% confidence level, and the most recent review cycle's population size will be used. A review of the most recent review cycle results will provide the response distribution percentage. The state considers each performance measure percentage from the recent review cycle. The lowest performing percentage is used as a response distribution in the calculation of the following review cycle's sample size. Findings are compiled, reviewed by the waiver manager, if appropriate addressed in a plan of correction, and summarized in a report issued to the qualified provider, the DHS/DDD Director and SSMA.

Financial transactions and claims submissions are also monitored as a component of the PERM process. Waiver claims are included in the sample population for PERM and are reviewed for accuracy as part of this process. All claims adjudicated through the MMIS fall under the authority of the DSS Surveillance and Utilization Review System (SURS). The SURS unit is staffed with investigators who seek and review paid claims to find inappropriate or incorrect payments to providers, and then implement any needed corrective actions. The DHS/DDD, State Medicaid Agency and SURS continually assess the need for additional post-payment review strategies within the waiver.

The primary goal of the SURS Unit is to safeguard the South Dakota Medicaid program. The billing review ensures financial accountability and integrity within the waiver. If the state's review results in a suspected provider fraud, the case is referred to South Dakota Medicaid Fraud Control Unit (SD MFCU) under the terms of its Memorandum of Understanding. SD MFCU provides the State Medicaid Agency with written notice any time it accepts a referral, declines a referral, or closes an investigation by way of conviction, acquittal, or declination of prosecution. On a quarterly basis, DSS requests a certification from SD MFCU, or other law enforcement agency of any matter accepted on the basis of a referral under investigation, thus warranting continuation of any payment suspensions. The SURS Unit applies the same core review strategy elements to South Dakota Medicaid Waiver services as it does for medical services provided to recipients under the State Plan. DSS SURS and DHS billing reviews ensure staff from both agencies to maximize the use of available investigative resources at their disposal and communicate more effectively during the preliminary investigation period.

The Department of Legislative Audit (DLA) conducts the State of South Dakota's annual independent audit and ensuring that it complies with the with OMB Uniform Guidance 2 CFR Chapter I, Chapter II, Part 200, et al Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards by an auditor approved by the Auditor General to perform the audit. DLA audits are conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. In accordance with Government Auditing Standards, DLA also reviews internal controls over financial reporting and tests compliance with certain provisions of laws, regulations, contracts, and grant agreements. Upon completion of the Single State Audit, DLA submits copies to each Department Secretary and Director of Budget and Finance. The DHS' Office of Budget & Finance is responsible for coordinating all responses to the Single State Audit and gathers all pertinent information for any necessary response.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of claims paid accurately for an approved service for eligible waiver participants. Numerator: The number of sampled claims that are correct.

Denominator: The total number of sampled claims.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

<i>Responsible Party for data collection/generation (check each that applies):</i>	<i>Frequency of data collection/generation (check each that applies):</i>	<i>Sampling Approach (check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
<i>Other Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<i>Annually</i>	<i>Stratified</i> Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<i>Continuously and</i>	<i>Other</i>

	Ongoing	Specify: Proportionate sample; 95% confidence level; 5% confidence interval
	Other Specify: All providers will be reviewed in a two year period; 1/2 in one year and 1/2 in the next year.	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: 	Annually
	Continuously and Ongoing
	Other Specify:

- b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of provider payment rates that are consistent with rate methodology approved in the approved waiver. Numerator - Number of provider payments that are consistent with rate methodology and appropriate rate. Denominator - Total number of reviewed payments.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; padding: 5px;"> Proportionate sample: 95% confidence level; Confidence interval 5% </div>
	Other Specify:	

	<i>All providers will be reviewed in a two year period, 1/2 in one year and 1/2 in the next year.</i>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The DHS/DDD implemented an online review system to compile and calculate a Financial Accountability performance measure for the CHOICES waiver. SMART (Systemic Monitoring and Reporting Technology) facilitates DHS/DDD and DHS/Office of Budget & Finance review of compliance with Financial Accountability requirements including qualified provider claims review. SMART aligns existing quality assurance and improvement processes with federal reporting requirements while concurrently producing meaningful information for systemic improvement. SMART engages qualified providers in the remediation of problems discovered and systemic improvement of their certification requirements. It is also available to DHS/DDD staff, DHS/Office of Budget & Finance staff, the SSMA and qualified providers as a tool to generate agency specific reports to monitor and trend improvement progress.

The SMART system enables the DHS/DDD to query Financial Accountability performance data to monitor for systemic trends in compliance with the approved reimbursement methodology. A DHS Management Analyst performs a review of payments for waiver services to ensure each claim billed meets waiver qualifications. All claims billed in the sampling period are susceptible for review. The qualified provider is informed of the review date(s) and the sampled claims. The Management Analyst reviews documentation of services and if necessary, requests clarification or additional information from the qualified provider. The Management Analyst reviews all documentation to ensure payment was correct according to processing and payment methodologies and to ensure the claim was billed and paid according to the services authorized by waiver policy. Individual problems discovered during the review must be fixed within a reasonable timeframe specified by the DHS/DDD. Systemic issues are addressed biennially through a qualified provider plan of enhancement process. The Quality Assurance Manager is responsible for aggregating quarterly and annual information for analysis by the Internal Waiver Review Committee (IWRC) and the Core Stakeholders Group. Their findings and recommendations are reported to the DDD Director and the SSMA for remediation.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DHS/Office of Budget & Finance claims reviews serve as the primary discovery activity for individual problems related to Financial Accountability. Claims review findings are summarized in a report issued to the qualified provider, the DHS/DDD Director, the B&F Director, and the DHS/DDD Program Specialist. An error rate is calculated based on the total dollars found in error versus the total dollars reviewed. The qualified provider is required to complete individual claims adjustments within 60 days of the date they receive the report of findings from the review. If a qualified provider is found to have an error rate greater than five percent this results in a follow-up review approximately four months later. The DHS Management Analyst tracks each incorrect claim to ensure an appropriate adjustment is made. The DHS Management Analyst follows up with the qualified provider if timely adjustment is not made.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;"> Internal Waiver Review Committee Core Stakeholders Group </div>	Annually
	Continuously and Ongoing

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Individual Resource Allocation (IRA) model currently in use supports people and qualified providers to utilize person-centered planning to determine an appropriate array of services and supports. Qualified Providers utilize an internet based information system (Service Record) to identify the services provided to each person. The Service Records are audited onsite, as described in the Quality Improvement section of this appendix, by DHS fiscal staff to ensure that people are receiving the services reported on the Service Record. Waiver services and individualized information can then be entered into the model to generate an individualized rate for each person based on the services and supports the person needs.

If a person experiences a temporary additional but significant need, the qualified provider may request Extraordinary Needs Funding (ENF). These requests require supporting documentation and are reviewed by DHS/DDD staff for approval/denial and are paid using state general fund dollars.

If a person's needs or preferences change, providers can make a significant change request (SCR) that could adjust the daily service rate to accommodate the change. The SCR requires supporting evidence that the change is person-centered and are reviewed by DHS/DDD staff. If a short-term extraordinary need arises in order to mitigate the likelihood of a crisis including institutionalization, the provider may complete a DHS/DDD issued form to request a one-time 100% general fund payment to cover remaining costs after all other alternatives have been exhausted. The DHS/DDD has an ENF review team that reviews the requests and makes a recommendation for approval/disapproval to the DDD Director. A SCR request allow for a person and their team to request a long-term change to their waiver service(s). If the request is linked to an allowable waiver service not covered by the State Plan, the SCR process is generally used instead of the ENF process.

The person's case manager will submit a completed SCR form to the state for review and approval after the person's team agrees on the change. If approved the change is ran through the IRA model to calculate a new IRA. The SCR describes the service(s) being changed, the effective date, the reason for the change, and is signed by involved parties. Generally, SCRs are required for changes expected to last 60 days or longer. An example of a common SCR is when a person's ICAP scores change due to a change in health, adaptive skills or maladaptive behaviors.

Every participant's IRA is calculated using the IRA/multiple regression algorithm. The ISP team determines the necessary waiver supports and services needed the achieve a good life for the participant. Those parameters decided by the ISP team are entered into the IRA/multiple regression algorithm which is designed to generate a resource allocation for provider reimbursement. The IRA is calculated as SCRs are submitted to the state or at least annually.

Background of Developing the IRA Model

The rate model draws information from many sources to generate an individualized rate for each person based on the services and supports needed by the individual. Qualified Providers committed significant time to participate in workgroups that developed the model.

1. Cost reports from each qualified provider agency are used to compile the system-wide average cost per service. Each qualified provider is required to submit an annual independent audit. Within the audit is a Statement of Expenses & Revenues which serves as the agency cost report. The DHS/DDD prescribes the format for the Statement of Expenses & Revenues. The cost report format prescribes the listing of accounts with actual and allocated costs for each service center. This information is validated and compiled by DHS fiscal staff. If federal funds of \$750,000 or more have been received by the provider the audit shall be conducted in accordance with OMB Uniform Guidance 2 CFR Chapter I, Chapter II, Part 200, et al Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards by an auditor approved by the Auditor General to perform the audit. Audits shall be completed and filed with the Department of Legislative Audit by the end of the fourth month following the end of the fiscal year being audited or 30 days after receipt of the Auditor's report, whichever is earlier.

2. Activity logging is used to identify the number of units of services provided to each person. That amount is multiplied by the average cost of each service to determine a cost of service for each person. Activity Logging (time study) Data is gathered in anticipation of creating a new Individual Resource Allocation (IRA) model. Qualified Providers utilize an internet based application to submit activity logging information that reports the number of units of each service provided to each waiver participant. This information is gathered for a statistically representative time period. The internet application has on-line edits that prevents errors. Summary edits also identify potential issues that prompt providers to review information prior to submission. DHS/DDD staff conduct on-site visits to provide technical assistance to qualified providers during activity logging and review the information that is gathered and reported. Activity logging is gathered in anticipation of a remodel as recommended by the DD Advisory Group.

3. Case Managers must submit an ICAP (The Inventory for Client and Agency Planning is a standardized tool that

assesses an individual's adaptive skills and maladaptive behaviors) for each person receiving HCB services. Certain elements of the ICAP are weighted in the IRA model calculation based upon recommendations made by the DD Advisory Group. As a result, parameter estimates within the IRA model were established in order to weight those elements of the ICAP and applied to more accurately predict an adequate resource allocation.

4. Multiple regression is used to formulate a model which predicts the cost of each waiver service an individual will need based on the services they receive and their needs as assessed by the ICAP. Cost per person serves as the dependent variable and variation in rates are determined based on level of need. Information from Service Records, ICAPs and economic measures serve as potential independent variables.

Providers submit annual cost reports used to compile the system-wide average cost per service. Allowable costs are described within the Cost Report Guidelines updated annually. A time study (activity logging) is used to identify the number of units of service provided to each person within each service category. That amount is then multiplied by the average cost of each service to determine a cost of service for each person. The ICAP is also used within the IRA calculation to consider a person's specific needs and abilities (adaptive skills and maladaptive behaviors). Stakeholders advised the state to weight certain ICAP components within the IRA calculation.

The cost report template and guidelines are kept current on our website for provider and public access. The link is <http://dhs.sd.gov/budgetandfinance.aspx> and information can be found under the Community Support Provider section.

The generation of an IRA is based on statistical analyses of activity logging information, cost reports, and ICAP data representing all the people in the service delivery system. These datasets, or predictor measures, are ran through a multiple regression process which calculates a parameter estimate for each predictor measure. Predictor measures are established by the state in close partnership with its stakeholders and are considered key drivers of costs/time/effort within the service delivery system. Parameter estimates represent the predicted costs associated with a specific predictor measure. Each parameter estimate is added to determine the IRA amount. This process allows for the allocation of resources based upon the individual's intensity of needs, mix of services and the settings in which they are provided, and ICAP scores. To illustrate, the ICAP service score is a predictor measure that has a parameter estimate of a negative value and as such the IRA goes down as ICAP service scores go up because generally a higher service score correlates with lesser needs. Conversely, the parameter estimate for the mobility assistance predictor measure is a positive value because generally the greater need for mobility assistance correlates with higher needs. In this example the parameter estimate values for both ICAP service and mobility assistance are added to calculate the IRA. The state uses a software platform to house and maintain the IRA/multiple regression algorithm.

The conflict-free case management rate was derived in October 2015 from the Community Support Provider cost report data from salaries, benefits, taxes, and overhead for existing case managers. South Dakota Department of Labor wage statistics were used to validate the cost report data. Rate adjustments will be calculated using the inflationary rate approved for qualified providers by the South Dakota State Legislature. The state will rebase the case management rate on a 5-year cycle.

- b. Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Appendix I-2a describes how each participant's daily rate and case management rate are determined. The qualified provider is certified as an OHCDs by the DHS/DDD pursuant to ARSD Article 46:11. The qualified provider is notified of the person's daily rate and the rate file is uploaded to the DSS MMIS. All waiver services are billed by the qualified provider via an electronic billing submitted by the qualified provider to the DSS MMIS. Once a claim is submitted to the DSS MMIS, the claim goes through a pricing process and the DSS MMIS calculates payment based upon information within the rate file. The DSS MMIS computes service level expenditures prior to processing claims and generating qualified provider remittance advices. Service level expenditures are assigned budgetary coding and are queried from the DSS MMIS for reporting purposes.

HCBS waiver dollars are used only to fund the approved services in the waiver. If an individual is eligible for both special education services and HCBS, the Individual Education Plan (IEP) team can choose to receive supports from a qualified provider. All waiver participants receiving special education services are documented within the MMIS with a specific and unique identifier indicating they are a child eligible for CHOICES waiver services. This identifier means educational services are calculated separately for the rates that will be provided to the child, thus preventing duplication of payment for waiver services and Individuals with Disabilities Education Act (IDEA) related services. The rate for waiver services is then uploaded to the MMIS which only allows the qualified provider to bill for the authorized federal amount of waiver services. All existing checks for Medicaid waiver services within the MMIS are applied. All IDEA-related services and the non-federal matching share for individuals under the age of 21 are funded by the South Dakota Department of Education and payments are attested prior to the expending of FFP as described in Appendix I-4-a. The state uses the OHCDs arrangement for qualified providers who are not case managers to purchase supplies/equipment from vendors who are not Medicaid providers. Supplies and equipment participants receive from vendors who are not qualified providers must be authorized through the plan of care. The qualified provider purchases the supplies/equipment and makes arrangements for delivery to the participant. The qualified provider bills the DSS MMIS for the supplies/equipment.

DSS exercises administrative authority and oversight of the waiver and authorizes and pays all waiver claims through the DSS MMIS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

When an applicant / participant does not meet the waiver level of care, the DSS Benefits Specialist updates the MMIS reflecting the appropriate period of eligibility/ineligibility. The MMIS will only pay those waiver claims submitted for a participant with a date of service within level of care eligibility timeframes.

The internet based service record maintains a current listing of participant's approved plan services approved by a DHS/DDD Program Specialist. The participant's approved plan generates a corresponding rate based on the individual's specific needs and services. This information is compared electronically with the information submitted by the provider invoice. Claims that don't match are pended/denied.

A Management Analyst within DHS/Office of Budget & Finance performs an internal review of payments for waiver services. The Analyst selects a representative random sample of claims from each qualified provider and reviews the associated services billed during a specified time period. The qualified provider is informed of the review date and the sampled participants. The Analyst reviews documentation of services (service plan, service coordinator monitoring notes, etc.) and if necessary, requests clarification or additional information from the qualified provider. The Analyst reviews all documentation to ensure payment was correct according to processing and payment methodologies and to ensure the claim was billed and paid according to the services authorized by waiver rules. The review findings are summarized in a report issued to the provider, the DHS/DDD Program Specialist, and the DHS/DDD Director. The SSMA reviews the findings quarterly. Identified errors are addressed and corrected.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through

which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

The South Dakota Dept. of Human Services/Division of Developmental Disabilities (DHS/DDD)) will issue Shared Savings payments for Community Support Providers participating in care coordination agreements with the Indian Health Service. The source of the non-federal share of the supplemental payment is state general funds. Eligible Community Support Providers will retain 100% of the total computable expenditure claimed by the Medicaid agency to CMS.

DHS/DDD will make supplemental payments to further these goals to the following private providers in the following amounts. Savings below are based on claims paid during the calculation period:

<i>Provider</i>	<i>Amount</i>
<i>Community Connections Inc</i>	<i>\$95,199</i>

Supplemental payments will be made using data calculated for the period of May 1 to December 31. Payments for the supplemental payment period will be made during the third quarter of the state fiscal year.

Shared savings payment amounts are based on the amount of care coordinated by the provider and IHS.

South Dakota Medicaid is issuing payment for the state general fund payment amount and is requesting federal match.

Providers must enter into a coordinated care agreement with the Indian Health Service that resulted in general fund savings to become eligible for supplemental payments. A provider is able to execute a coordinated care agreement at any point during the fiscal year.

Appendix I: Financial Accountability***I-3: Payment (4 of 7)***

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

Yes. State or local government providers receive payment for waiver services. *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability***I-3: Payment (5 of 7)***

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

Entities are designated as an OHCDS when they meet the criteria outlined in ARSD Article 46:11. This includes being certified as a CSP or SP, having a signed provider agreement with the SSMA and the DHS/DDD, and provide at least one service covered under the provisions of ARSD Article 67:16.

If a provider does not voluntarily agree to contract with an OHCDS the provider may contract directly with the SSMA and the DHS/DDD and meet the requirements of ARSD Article 46:11 to become a certified agency.

Each participant is informed upon application and annually of their right to choose their provider. The DHS/DDD ensures this information is provided to each participant at the time of application during review of the application for waiver services. To ensure this information is provided to the participant annually the DHS/DDD reviews for this during the representative random sample participant file review process.

The OHCDS is accountable for ensuring that the individual providers delivering services meet all of the state's applicable waiver standards. The DHS/DDD monitors OHCDS compliance of waiver requirements by way of quality assurance reviews.

Financial accountability is maintained at several levels. The OHCDS is required to complete an annual contract with the DHS that provides detailed instructions as to how waiver funding may be utilized. Participant plans are reviewed at the state level to ensure that waiver funding is assigned to participants to pay for supports and services that meet waiver requirements. Each OHCDS is required to conduct and submit an annual audit, undergo a representative random sample review of all claims, and submit to monitoring conducted by DHS as a component of the PERM. All claims adjudicated through the MMIS fall under the authority of the DSS Surveillance and Utilization Review System. This system is staffed with investigators who seek and review paid claims to find inappropriate or incorrect payment to providers.

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the

geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

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Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

--

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Non-federal match of claims submitted by qualified providers of CHOICES waiver services provided to children where a local school district (LSD) utilizes appropriated funds for the non-federal share of these waiver services are addressed through an Intergovernmental Transfer (IGT) where the LSD transfers funding to the DHS.

Once the funding has been receipted from the LSD via the IGT, 100% of total computable costs for each claim will be adjudicated through the MMIS and paid to the qualified provider. This process will require an appropriation of expenditure authority which will be requested and ultimately require approval by the SD Legislature. It is the intent of both DSS and DHS to implement this new process when approved by the SD Legislature on July 1, 2014, the beginning of state fiscal year 2015.

When LSDs are responsible for the non-federal share of services provided, the qualified provider submits a monthly claim to the DSS/MMIS which is pended until the non-federal match and attestation form has been receipted by DHS from the responsible LSD. The claim is submitted after services are rendered and based on the service rate established by the DHS in accordance with the approved methodology outlined in Appendix I-2-a. Services included in a child's Individualized Educational Plan (IEP) are not included in the DHS rate. Therefore, the rate in which Federal Financial Participation (FFP) is based on does not include IEP services. Neither Medicaid dollars nor non-federal match is expended towards IEP services. The LSD reviews the bill for accuracy. Once the LSD determines the bill to be accurate, the LSD submits payment and attestation of the non-federal match to DHS as an IGT. DHS receipts the payment from the LSD as revenue and audits the payment toward the claim submitted by the qualified provider. If during the audit it is determined that the claim is not in accordance with the rate file and service record data, the claim and attestation is denied and sent back to the qualified provider and the LSD for revision. If it is determined during the audit that the claim is in accordance with the rate file and service record data, the DHS notifies DSS that the claim is validated and can be released for payment of 100% of total computable costs by DSS via the MMIS.

The IGT process ensures that 100% of total computable costs for all waiver claims are paid by the SMA through the MMIS to a qualified provider. As such, this will also ensure that pre/post eligibility review is being performed and that full payment is being made to the qualified provider.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Rates for services and supports in this waiver application exclude room and board costs. Qualified provider incurred costs for room and board is excluded from cost report service centers used for rate setting purposes. Payment will only occur for those services defined in this waiver application. Each agency or provider is contractually required to ensure that waiver funds will not be used to cover room and board costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

No. The state does not impose a co-payment or similar charge upon participants for waiver services.

Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

*Coinsurance**Co-Payment**Other charge**Specify:*

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Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)****a. Co-Payment Requirements.****ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

No. *The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.*

Yes. *The state imposes a premium, enrollment fee or similar cost-sharing arrangement.*

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	46197.42	4556.00	50753.42	206162.00	4647.00	210809.00	160055.58
2	47248.33	4693.00	51941.33	212346.00	4787.00	217133.00	165191.67
3	48315.33	4834.00	53149.33	218716.00	4931.00	223647.00	170497.67
4	49412.95	4979.00	54391.95	225277.00	5079.00	230356.00	175964.05
5	50536.85	5128.00	55664.85	232035.00	5231.00	237266.00	181601.15

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	2709		2709
Year 2	2726		2726
Year 3	2743		2743
Year 4	2760		2760
Year 5	2777		2777

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (2 of 9)**

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is calculated by using the total days of waiver coverage calculated annually by the DSS MMIS divided by the unduplicated count of participants on the waiver. The length of stay from the current waiver is being utilized. This number will be adjusted based on actual data for future 372 reports and renewals.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

The estimated annual average per capita Medicaid cost for home and community based services for individuals in the waiver program as projected in FY2017 adjusted for an approximate 3% increase after projecting growth in eligible participants and inflation. The state's data source includes actual growth and expenditures from the last three years of the waiver. The State uses CPI-U in its inflation determinations and the 3% increase estimate is based on historical inflationary trends from the previous three years.

The initial dataset is the state's preliminary 372 report for FY17. The historical averages used to adjust the FY2017 dataset came from the state's lag 372 reports from FY2014, FY2015 and FY2016. For example, the lag reports from FY14-16 and the preliminary report from FY17 reported total number served of 2,604, 2,633, 2,650, and 2656, respectively. This growth equates to an annual increase in average persons served of 17, or .897%. As a result, .897% rounded up to 1% (about 17 people) increase in people served was added to each waiver year after FY2017. Expenditures were calculated in a similar fashion except 3% was used to increase total waiver expenditures in each year based on historical expenditure data from FY2014 through FY2016 lag 372 reports where we realized on average about a 3% total expenditure increase.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimated annual average per capita Medicaid cost for State Plan services for current individuals in the waiver program as projected in FY2017 along with projected growth in eligible participants for the five year period (based on a three year historical growth average from 372 reports) adjusted for a 3% annual increase for inflation. The State uses CPI-U in its inflation determinations and the 3% increase estimate is based on historical inflationary trends.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimated annual average per capita Medicaid cost for ICF-ID/DD care in FY2017 (that would be incurred for individuals served in the waiver, were the waiver not granted) adjusted for a 3% annual increase for inflation. The State uses CPI-U in its inflation determinations and the 3% increase estimate is based on historical inflationary trends.

iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The estimated annual average per capita Medicaid costs in FY2017 for State Plan services (other than those included in Factor G for individuals served in the waiver, were the waiver not granted) adjusted for a 3% annual increase for inflation. The State uses CPI-U in its inflation determinations and the 3% increase estimate is based on historical inflationary trends.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

<i>Waiver Services</i>	
<i>Career Exploration</i>	
<i>Case Management</i>	
<i>Day Services</i>	
<i>Residential Habilitation</i>	
<i>Supported Employment</i>	
<i>Medical Equipment and Drugs</i>	
<i>Nursing</i>	
<i>Other Medically Related Services - Speech, Hearing & Language</i>	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						9478194.52
Career Exploration	Hour	873	1022.32	10.62	9478194.52	
Case Management Total:						5483016.00
Case Management	15 minutes	2709	160.00	12.65	5483016.00	
Day Services Total:						22690045.04
Day Services	Hour	1994	1440.40	7.90	22690045.04	
Residential Habilitation Total:						70205835.91
Residential Habilitation	Day	2461	348.66	81.82	70205835.91	
Supported Employment Total:						5444896.98
Individual Supported Employment	Hour	234	236.95	54.99	3048992.04	
Group Supported Employment	Hour	234	189.75	53.96	2395904.94	
Medical Equipment and Drugs Total:						1125146.70
Medical Equipment and Drugs	Hour	1508	99.35	7.51	1125146.70	
GRAND TOTAL:						125148817.91
Total Estimated Unduplicated Participants:						2709
Factor D (Divide total by number of participants):						46197.42
Average Length of Stay on the Waiver:						347

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nursing Total:						8892003.28
Nursing	Hour	2696	248.36	13.28	8892003.28	
Other Medically Related Services - Speech, Hearing & Language Total:						1829679.48
Other Medically Related Services - Speech, Hearing & Language	Hour	2074	149.02	5.92	1829679.48	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						125148817.91 2709 46197.42 347

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						9756878.96
Career Exploration	Hour	878	1022.32	10.87	9756878.96	
Case Management Total:						5683164.80
Case Management	15 minute	2726	160.00	13.03	5683164.80	
Day Services Total:						23375589.02
Day Services	Hour	2006	1440.40	8.09	23375589.02	
Residential Habilitation Total:						72291248.08
Residential Habilitation	Day	2476	348.66	83.74	72291248.08	
Supported Employment Total:						5491434.56
Individual Supported Employment	Hour	236	236.95	54.99	3075051.80	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						128798945.65 2726 47248.33 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Group Supported Employment	Hour	236	189.75	53.96	2416382.76	
Medical Equipment and Drugs Total:						1158990.28
Medical Equipment and Drugs	Hour	1517	99.35	7.69	1158990.28	
Nursing Total:						9156951.24
Nursing	Hour	2713	248.36	13.59	9156951.24	
Other Medically Related Services - Speech, Hearing & Language Total:						1884688.72
Other Medically Related Services - Speech, Hearing & Language	Hour	2087	149.02	6.06	1884688.72	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						128798945.65 2726 47248.33 349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						10049487.39
Career Exploration	Hour	884	1022.32	11.12	10049487.39	
Case Management Total:						5889769.60
Case Management	15 minute	2743	160.00	13.42	5889769.60	
Day Services Total:						24050546.05
Day Services	Hour	2019	1440.40	8.27	24050546.05	
Residential Habilitation Total:						74443986.49
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						132528939.54 2743 48315.33 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation	Day	2492	348.66	85.68	74443986.49	
Supported Employment Total:						5537972.14
Individual Supported Employment	Hour	238	236.95	54.99	3101111.56	
Group Supported Employment	Hour	238	189.75	53.96	2436860.58	
Medical Equipment and Drugs Total:						1192420.56
Medical Equipment and Drugs	Hour	1527	99.35	7.86	1192420.56	
Nursing Total:						9424516.92
Nursing	Hour	2730	248.36	13.90	9424516.92	
Other Medically Related Services - Speech, Hearing & Language Total:						1940240.40
Other Medically Related Services - Speech, Hearing & Language	Hour	2100	149.02	6.20	1940240.40	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						132528939.54 2743 48315.33 349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						10351715.85
Career Exploration	Hour	889	1022.32	11.39	10351715.85	
Case Management Total:						6102912.00
Case Management	15 minute		160.00	13.82	6102912.00	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						136379728.47 2760 49412.95 349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		2760				
Day Services Total:						24778581.83
Day Services	Hour	2031	1440.40	8.47	24778581.83	
Residential Habilitation Total:						76649006.47
Residential Habilitation	Day	2507	348.66	87.69	76649006.47	
Supported Employment Total:						5561240.93
Individual Supported Employment	Hour	239	236.95	54.99	3114141.44	
Group Supported Employment	Hour	239	189.75	53.96	2447099.49	
Medical Equipment and Drugs Total:						1228442.88
Medical Equipment and Drugs	Hour	1536	99.35	8.05	1228442.88	
Nursing Total:						9708345.21
Nursing	Hour	2747	248.36	14.23	9708345.21	
Other Medically Related Services - Speech, Hearing & Language Total:						1999483.30
Other Medically Related Services - Speech, Hearing & Language	Hour	2113	149.02	6.35	1999483.30	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						136379728.47 2760 49412.95 349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Career Exploration Total:						10659475.06
Career Exploration	Hour	895	1022.32	11.65	10659475.06	
Case Management Total:						6322673.60
Case Management	15 minute	2777	160.00	14.23	6322673.60	
Day Services Total:						25496578.02
Day Services	Hour	2044	1440.40	8.66	25496578.02	
Residential Habilitation Total:						78932715.52
Residential Habilitation	Day	2523	348.66	89.73	78932715.52	
Supported Employment Total:						5607778.51
Individual Supported Employment	Hour	241	236.95	54.99	3140201.20	
Group Supported Employment	Hour	241	189.75	53.96	2467577.31	
Medical Equipment and Drugs Total:						1264087.67
Medical Equipment and Drugs	Hour	1546	99.35	8.23	1264087.67	
Nursing Total:						9998206.17
Nursing	Hour	2763	248.36	14.57	9998206.17	
Other Medically Related Services - Speech, Hearing & Language Total:						2059307.38
Other Medically Related Services - Speech, Hearing & Language	Hour	2126	149.02	6.50	2059307.38	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						140340821.93 2777 50536.85 349